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HOME HEALTH CARE IN MAINE: WILL IT BE THERE WHEN YOU NEED IT?

A BRIEFING

BY THE

SUBCOMMITTEE ON HUMAN SERVICES

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

SEPTEMBER 4, 1986, AUBURN, ME

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HOME HEALTH CARE IN MAINE: WILL IT BE THERE WHEN YOU NEED IT?

THURSDAY, SEPTEMBER 4, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HUMAN SERVICES,
Auburn, ME.

The subcommittee met, pursuant to notice, at 10:05 a.m., in the auditorium, Central Maine Vocational Institute, Hallowell Annex, 1250 Turner Street, Auburn, ME, Hon. Olympia J. Snowe (acting chairwoman of the subcommittee) presiding.

Member present: Representative Snowe.

Staff present: Barbara Kaplan, minority staff director, Subcommittee on Human Services.

OPENING STATEMENT OF REPRESENTATIVE OLYMPIA J. SNOWE

Ms. SNOWE. Good morning, ladies and gentlemen. The hearing will come to order.

Thank you. It is with great pleasure that I call to order this field hearing of the Subcommittee on Human Services of the Select Committee on Aging.

As you know, we are here today to discuss home health care, particularly that part which is reimbursed by Medicare. When I speak of home health care, I am talking about the care that is provided under the direction of a physician for individual and needed skilled nursing services or physical or speech therapy. While we will not be able to focus in this hearing on home care that is funded through other sources, this should not be construed to mean that these services are less important than the Medicare services.

On the contrary, the full range of home care is an essential element in assuring that older persons receive the most appropriate level of care and that they are not institutionalized needlessly. Home care is a humane and in some cases cost effective method of delivering care to our older population. Today we will focus on only one part of the home care picture in an effort to determine what factors are impinging upon the ability of Medicare providers to provide home health care.

While home care is funded through many sources, such as medicaid, the Older Americans Act, and title XX of the Social Security Act, that part which is financed through Medicare has come under particular pressure recently as a result of changes in the reimbursement methodology. While the issues are technical ones which create administrative problems, they ultimately result in a restric-

tion of available services because home health agencies are less able to provide the needed care.

The restriction in the supply of Medicare reimbursed services comes at a time when the demand for these services has increased markedly. As we all know, the number of persons 65 and over is growing. In Maine about 12 percent of the population is 65 and over, and in some areas, such as in Lewiston and Hancock County, that figure is as high as 15 percent. Of those 65 and over, more than 4 out of every 10 are 75 or above. Because utilization of home health care increases dramatically with age, it is reasonable to expect an increased need for home health care based sheerly on the numbers.

In addition to the demographics of an aging society, however, there are other factors which are operating within the health care system. Most particularly, I am thinking about the implementation of the prospective payment system under which Medicare reimburses the hospital a preset amount based on the patient's diagnosis. Hospitals that spend less than the fixed fee can keep the profits. Those that spend more must absorb the losses. As a consequence, the incentives have changed so that hospitals are discharging patients early. Thus, as the length of stay for each hospitalization has decreased, the likelihood has increased that individuals will be discharged into the community earlier. As a result, the need for home and community based care, particularly skilled care, has grown.

Clearly, there are many questions to be answered. For that reason, I am pleased to have three distinguished panels of witnesses here today who can address the issue of home health care and who can help us to identify the problems and to explore ways in which to remedy these problems.

I might say also, at the outset, if there are those of you who have testimony that you would like to submit, the record will be kept open for that purpose. I would welcome anybody who has such testimony to submit it to my office.

In the first panel, we will hear about home health care from those in the best position to know about the care that is provided, those who themselves are recipients. I am delighted to present the first panel here this morning.

Ms. Laurel Atkinson is well known to many of us here. Professionally, Ms. Atkinson was a certified occupational therapist assistant before she retired. More recently she was a VISTA volunteer with the Maine Committee on Aging where she received a commendation from the Governor for her fine work.

Mrs. Rose Patrizio and her daughter, Rose Marie Wunder, are joint caregivers of their husband and father. A stroke made it impossible to keep Mr. Patrizio home any longer. Mrs. Patrizio was able to care for her husband with help from her daughter and the services of professional home health providers.

Finally, Margaret Russell will speak to us as the chairperson of the Maine Committee on Aging. While she has not been a recipient of home care herself, Margaret can tell us about older persons throughout Maine who have shared their experiences about such care. I would like to welcome the first panel here today.

I would ask you to summarize your written statements and we will incorporate the full text of the statement in the record. I certainly welcome your comments here this morning, and I know that you will provide invaluable information as we begin to explore this very important issue for the State and the country.

Why not begin with Ms. Atkinson.

PANEL ONE—HOME HEALTH CARE RECIPIENTS: CONSISTING OF LAUREL ATKINSON, HOME HEALTH CARE RECIPIENT; MARGARET RUSSELL, CHAIRPERSON, MAINE COMMITTEE ON AGING; AND ROSE PATRIZIO AND HER DAUGHTER, ROSE MARIE WUNDER, JOINT FAMILY CAREGIVERS

STATEMENT OF LAUREL ATKINSON

Ms. ATKINSON. My name is Laurel Atkinson. I am 75 years old. I have worked all my life for the welfare of others less fortunate than myself. I have worked over 25 years helping emotionally upset senior citizens and many retarded people. I have worked in occupational therapy and have done some counseling.

At the present, I am bedbound, but I can still see people and use the telephone. That was before I was fortunate enough to get my cart. I have congestive heart failure, arthritis, and dehydration of the cerebellum. The latter is the reason I am bedbound as it affects my balance and I fall continuously. I have been receiving medicare and home health services which I could not do without. I have a nurse visit twice a month, once to draw blood and second just for a general checkup. One important thing is my blood platelet count—it goes very high so it has to be tested often.

A health aide also bathes me twice a month and shampoos my hair. I cannot get in and out of the tub, nor lift my arms above my head. I don't know what the devil I would do without these girls. If I didn't have them, I would have to give in and be bedridden. Nursing homes to me leave a lot to be desired. I investigated the law as it relates to nursing homes while I was working for the Maine Committee on Aging and reported back to Marge Blood. If I didn't have home health care I would have to give up and be bedridden and the nursing homes leave a lot to be desired and there aren't enough of them. Don't even mention a nursing home to me.

I also have a woman come in Monday, Wednesday, and Friday 4 hours each day to do general housekeeping and get me a meal. She cooks wonderful meals for me. For equipment, I have a hospital bed, bedside table, commode, and electric three-wheeler. Now I understand that once Medicare makes so many payments, I will actually own the equipment.

In July of 1983, I wrote a letter which I think is quite pertinent.

I wrote a letter to President Reagan, Senator Kennedy, Senator Mitchell, Senator Cohen, and Representative Claude Pepper.

Of all of them, Senator Kennedy was the only one to answer me and now here I am today saying the same things, fighting the same battles.

The time has come to stop playing politics with the elderly. That letter was written in 1983, and it is about the same subject on which we are speaking today. This is why I felt I ought to mention it, and it goes both to Social Security and Medicare. It keeps the

patients in an uproar every time this time of the year rolls around because they don't know whether they are going to be cut or whether they are going to be able to get a little bit more. Mostly it is cut.

Well, I know because I talk with them. And me, I am kind of feisty. I have been associated with various senior citizen groups throughout three counties, Androscoggin, Oxford, Franklin and I am in touch with them, many of them, by telephone. Now, I would like to speak my mind and their minds, and theirs was the same complaint that I had that every year they were thrown into a dither because they didn't know whether they were going to get what they had been getting or whether they were going to be cut back.

Another problem with Medicare is that if you are truthful about certain facts, you probably lose your benefits. For example, my doctor insists that I get out of the house as long as I can go with my electric chair. And now, one of the Medicare things I believe is that you are supposed to be absolutely bedbound. You can't get out. And that is a horrible life for anybody who has been working with the public as long as I have.

The doctor insisted I get out of the house as long as I can go with my electric chair. Of course, I need the home health system to even get into my chair. The irony is that if Medicare knew this, I might lose my home health benefits. The real truth is that my legs are getting weaker and my balance is getting poorer. I fell eight times on my way to the bathroom last winter and wound up in the hospital. If Congress would get together on Medicare and Social Security, we, the elderly, would not go through these scare tactics every year as to whether we get the money or the benefits. I know millions of dollars have been borrowed from Medicare and I don't think a nickel of it has been paid back.

I was told that $6 million was borrowed way, way, way back early from Medicare and it has never been repaid. It went into the armed services. I know millions of dollars have been borrowed from Medicare and I don't think a nickel has been paid back. It doesn't seem right.

Also, a good many people are getting thrown out of hospitals before they should because of the DRG's. And I think you will find out that if you inquire at the Stephens Memorial Hospital in the town that I live, you will find most of the doctors feel that way, that they are getting put out before they should.

What can you and the Congress—and the rest of the Congress do for us?

Thank you for the chance to speak my mind once more.

Ms. SNOWE. Thank you, Mrs. Atkinson.

Ms. Russell.

STATEMENT OF MARGARET RUSSELL

Ms. RUSSELL. I am Margaret Russell, chair of the Maine Committee on Aging. We are pleased to be here today to provide you with a consumer perspective on home health and to outline some of the critical issues affecting home care in Maine today.

As you know, Maine has experienced dramatic growth in the area of home care over the past 7 years. In 1979, the options for long-term care in Maine consisted of 8,500 nursing home beds and 3,500 boarding home beds. Care management was only a concept and the amount of funds spent on home care under Medicaid was a mere fraction of what was spent on nursing home care. This imbalance still exists today, even though tremedous progress has been made. In Maine, 5 to 8 percent of the Medicare Program is spent on home health and 3.4 percent of the Medicaid Program is spent on home health.

Today the Home Based Care Program, which was designed largely because Medicare home health does not meet the chronic long-term care needs available and the newly implemented Federal Medicaid Waiver Program has changed the landscape of long-term care. In 1985 the Home Based Care Program and the Medicaid Waiver Program served nearly 1,500 elderly clients in their home. In Maine, there are an estimated 12,000 individuals who need some sort of assistance in order to remain independent. Without home based care, many of these clients would have been placed inappropriately in nursing or board homes. Appropriateness of care aside, older people deserve long-term care options, and when provided with an option, most people opt to remain at home.

We agree with Laurel. The Maine Committee on Aging often receives calls from people who need assistance to stay at home. They tell us that they or their parent or their uncle doesn't want to go to a nursing home, but they need someone to come in and provide them with a little help. Providing long-term care is becoming a tremendous drain on the family and its resources. We feel certain that national figures hold in Maine that 80 percent of home care is provided by the family.

Mary W. is a typical client. Mary is a 63-year-old widow who lives alone. When she entered the Home Based Program she was suffering from rheumatoid arthritis, chronic circulatory problems, and severe leg ulcers. She had been in and out of the hospital numerous times and because of severe depression was not complying with the care plan. Placement in a skilled nursing facility was imminent. Under the area agency on aging care management and with the Home Based Care Program, she received skilled nursing, nurses' aides and homemaker services. Her care manager also arranged for her to move into the first floor of elderly housing and provided Mary with emotional support. Today, 6 months later, Mary no longer needs extensive services, is no longer at risk of institutionalization, and is once more again mobile and independent.

Fortunately, for people like Mary, the Home Based Care Program is flexible and can meet clients' needs in a variety of ways. Unfortunately, home health services funded by Medicare are much more rigid in their guidelines. Services must be delivered by a Medicare certified provider, a physician must certify that the patient needs intermittent skilled care, and the patient must be home bound to be eligible for reimbursement.

Rigid guidelines restrict access and the Maine Committee on Aging has received calls from clients who have been denied Medicare reimbursement. In some instances the denials for coverage can be excused as honest mistakes. In others, the actions appear to

be a direct result of an intentional design by the fiscal intermediary to reduce benefit payments. By design or default the results are the same. Some people will not receive the services necessary to afford them the opportunity to stay at home. One such case follows:

George D, 69 years old, has been visited weekly by a mental health nurse from a psychiatric hospital. He has been suffering severe depression after quadruple bypass surgery and having been forced to place his wife, an Alzheimer's victim, in a nursing home. As part of his therapy he was encouraged to tend a garden. Medicare denied coverage retroactively because George was not homebound because he left his house to attend his garden. George could not afford to pay for services himself and was forced to discontinue therapy.

The result of Medicare denials is a shift of the cost of medical care to other sources. The primary shift has been to the Medicare beneficiary who not only participates in Medicare through coinsurance and deductibles, but also through the limitations on payments, excluded items of coverage, and restrictions on the reimbursement rate. We must stop the myth that Medicare covers the health care bill of an older person. In fact, older people pay more out of pocket for health care as a percentage of income than they did prior to the enactment of Medicare. With limited income and resources, the elderly often make difficult choices between pauperization and the self-denial of care.

Recently, we received a call from a concerned citizen who has been going to pick up her vacationing elderly aunt's mail in a subsidized housing project. Her aunt's neighbor appeared one day and revealed an obviously injured arm. It was black and blue, scaly, and rather enlarged. The arm had been that way a full 6 weeks. The woman learned the neighbor had not sought Medicare treatment because her husband was fearful of the costs of medical care. We referred this patient to Adult Protective Services and later learned that the neighbor indeed had been suffering for 6 weeks from a broken bone. Unfortunately, self-denial of care is becoming more and more frequent.

To address this issue of Medicare denials, the Maine Committee on Aging initiated the development of a Medicare Advocacy Program modeled after Legal Assistance for Medicare Patients in Connecticut. This program will advocate on behalf of Medicare beneficiaries who have been denied reimbursement and will assist them with the appeals process. A feasibility study conducted for the Maine Committee on Aging by LAMP indicated that three conclusions can be reached about care being provided in Maine today:

One, it is very apparent that Medicare coverable home health services are being billed to the Medicaid Program. Therefore, an individual must pauperize himself in order to receive these services.

Two, in the absence of Medicaid eligibility, the home health agencies are shifting Medicare coverable expenses to the Home Based Care Program. Therefore, an individual must be lucky enough to receive these limited resources.

Three, in the absence of available Medicare coverage or Home Based Care Program payment, patients are receiving less care than is reasonable and necessary to meet their medical needs. Therefore,

they do not receive services to which they are entitled. Examples cited: 1 hour visit one time per week to meet personal care needs. For older patients who are homebound and in need of intermittent skilled care, elderly or infirm, one time per week is insufficient for proper health care.

It is the experience of LAMP Associates that the phenomenon occurring in Maine is not unique. For example, since 1981, the Medicare administration has changed its definition of part time or intermittent care at least four times, each time in a more restrictive manner I might add. The law did not change during this period. The feasibility study estimates that there are 1,500 cases in the home health area alone that could benefit from this program.

While we recognize the very real problem these present to administrators of programs, the consumer is not immune from negative ramifications. We have reached the point where the consumer needs an advocate to either assist in the appeals process in order to receive entitled benefits, or to assist the consumer to find the way through an increasingly confusing long-term care system.

While we are pleased with the development of home care systems for Maine's elderly the rapid growth of in-home services has created a number of unforeseen problems for the elderly consumer, which we believe need attention. Home care recipients are frequently nursing home eligible, frail and most often completely dependent on home care services. As with the provision of any service, the potential for individual problems increases exponentially with the number of cases handled.

In some parts of the State there is competition for needed personnel to provide home care services. This problem first surfaced with nursing homes having difficulty in recruitment and now it is spreading to the home care area, as well. The rate of reimbursement for these services must be considered.

We recently received a call from the niece of an 80-year-old woman who needed a personal care assistant three times a week to assist her with personal hygiene. The niece was distraught because her aunt had had over 20 different caregivers in the previous 3 months. Without question, having the same caregiver is crucial in maintaining a client's sense of dignity. A parade of caregivers is not a desirable or acceptable situation. We must assure that these valuable caregivers in Maine are reimbursed adequately and provided with health and pension benefits.

Home care is being touted as the available alternative to nursing home care. In Maine, this is not yet a reality. In addition to the problems cited about Medicare home health, the Medicaid Home Care Program is equally rigid and home based funds have been very limited until recently. The consumer needing home care has little security that services will be available to them.

A developing system exists in Maine which should be considered as a national model. In fact, the National Governor's Association is doing a study of seven States which have exemplary home care programs. We are proud that Maine is one of these States. The area agencies on aging play a crucial role in the delivery of long-term care services and their role should be considered carefully. These area agencies in Maine help the older consumer gain access into an extremely fragmented long-term care system. The area

agencies on aging are the focal point for long-term care services and coordinate services for the Home Based Care Program, the Medicaid waiver, Medicaid nursing home assessments and some Medicaid home health assessments.

The Maine Committee on Aging, in response to such home care issues, submitted legislation to the 112th Maine Legislature to expand their long-term care ombudsman program to cover clients receiving home care services. The legislation supported by the area agencies and private home health agencies is now part of the Maine Committee on Aging's enabling legislation.

As the Maine Committee on Aging looks to implement these new responsibilities, we will be working with both the Aging Network here in Maine and in other States, such as Wisconsin, which has taken on similar responsibility.

We look to the House Special Committee on Aging to take the lead in developing national policy in these areas, and we look forward to participation in that process as we respond to the issues in Maine.

Ms. SNOWE. Thank you.

Mrs. Patrizio.

STATEMENT OF ROSE PATRIZIO

Ms. PATRIZIO. Well, I will start by saying my husband is a bilateral amputee. He lost one leg in 1969 and then the second one in 1974. But we lived in New York at the time.

In October, we moved up to Maine, in October of 1979. And our first experience with the home health service was in September of 1980 when he had an infection on his stump.

The bone had to be operated on and the visiting nurse came to irrigate it three or four times a week. And then Sandey Pinker came in to take care of him. But then in April 1984, it seems that a lot of things started to happen and our first experience with the home health service was in May of 1984.

And at the time we had the home health nurse come, the aide came every single day for 7 days and gradually it was 5 days, and then recently it was 3 times a week. And, of course, every time the services were cut, my husband was getting worse, you know, he was bedridden at the time. And then in July—June and July, and in September, we had to hire a 3-hour aide through the home health services.

Well, now, it is Great Falls and then, of course, we had to pay for it. And then he had a catheter in February of 1985, and two or three times we had to call the agency after hours to change the catheter because it started to leak. And I don't know what I would have done if we didn't have the agency to do that.

Then he was in and out of the hospital for transfusions and all. And in July of this year he had the stroke. He had a stroke on his left side years ago, about 14 years ago, and then he had one on the right side in July of this year, which meant he couldn't use either hand.

So we tried to hire an aide for 8 hours and we did, but then I was the one who was up almost all night. And if we were to have a

nurse day and night, it would have cost a tremendous amount of money.

So now he is in a nursing home. He is in Russell Park Manor.

But the equipment we had at home, we had the concentrated oxygen tank. We had the commode. We have a Hoyer lift, we have three wheelchairs, we had an air mattress and a pump, but in spite of all this, I just couldn't keep him at home. And the days that we didn't have help, my daughter and her husband would come over to help me or relieve me, in spite of the fact that she has quite a family of her own and a farm. And he was never home alone. We never had him home alone. Somebody was always with him. So I don't know. I don't know what we would have done those 2 or 3 years now without the home health services. I couldn't imagine.

He would have been in a nursing home 6 or 8 months ago and you know how much the nursing home costs. And, in fact, the pharmacy that the hursing home deals with I found out charges from 12 to 19 cents a pill more than our local pharmacy. So I have cut them out and I will pick up the medication myself and bring it in whenever they need it.

So I don't know. These girls Debbie Rowe and Irene Terry, Rick Varney, all those people are now almost part of my family. In fact, I would like them to stay our friends and we did have a very nice lady who came in for 3 hours on a Tuesday and Thursday through Great Falls which, of course, we had to pay for. And, of course, we have to pay for the nursing home. Medicare doesn't pay for any of that.

Ms. SNOWE. Ms. Wunder, do you want to add anything to any of these comments?

STATEMENT OF ROSE MARIE WUNDER

Ms. WUNDER. Basically, my mother has said it all. One of the things that I would like to stress is that when we started with the agency, Medicare was providing more services. As my father's health deteriorated terribly, the services were cut down drastically to less than half of what we were originally receiving. Also, if I understand correctly, Medicare sort of feels that if you can pay for outside help in your home, then they should no longer provide their services.

Well, their services were the professional services that we were receiving. At the end it was only 3 days a week and only for 45 minutes a day. However, it was somebody who knew how to handle people who were terminally ill and who talked to the families, and we wanted to keep my father at home.

We could not do all the work ourselves and the moral support that these people gave us was—it was beyond payment. I mean, we could not have done it for the 3 years that we did. A while ago the doctor had told my mom that she should start looking into a nursing home, that he felt that she would not be able to handle it for the 2 years that she did, and we did do this as long as we could.

However, without professional help, we never would have been able to, and we did have to pay them at the end, 2 days a week, to come in and help out at home, but that was basically the only

relief that we got. Those 6 hours a week were the only relief that we got from caring for my dad.

Ms. SNOWE. May I ask if you were able to continue to pay for professional help, would your husband-father have been able to stay at home?

Ms. PATRIZIO. Well, day and night I think it would have been tremendous because I checked into it and I think the night aide would be $8 an hour and then during the day I did find an aide who would be $5 or $6 an hour. So that would be $64 and $40, over $100.

Ms. SNOWE. Were you informed that you would no longer be reimbursed because you were paying for professional help?

Ms. WUNDER. No; I don't think they ever told us that one. They did mention that we might not make too much about it and that they were thinking about cutting out Medicare. It was one of the things that was sort of on the books and they were talking about it.

Ms. SNOWE. So you only received relief for 6 hours a week?

Ms. PATRIZIO. Right—no, and then the aide came three times a week to bathe him.

Ms. SNOWE. And how many hours did that entail?

Ms. PATRIZIO. At that time that was only about 45 minutes or an hour. She would take care of him and maybe sit and talk to him for a few minutes or something like that.

Ms. SNOWE. So you fully depended on the entire family to assist?

Ms. PATRIZIO. Other than that, yes.

Ms. SNOWE. How much did it cost you in terms of home care?

Ms. PATRIZIO. The long-term care?

Ms. SNOWE. Yes.

Ms. PATRIZIO. That was $7.90 an hour. Well, when we started, I think it started at about $6, and then it gradually went up to $6.50 and $7. This last couple of months it went up to—June 14 I think the notice was it went up to $7.90 an hour. Say that is $48 a week right there, almost $48, anyway.

Ms. SNOWE. Was there any gap in service for your husband between his hospitalization and the start of home health care after he came home from the hospital?

Ms. PATRIZIO. No, that was very, very good. That surprised me. The day he came home from the hospital the nurse would be there. The nurse would come that afternoon and then, of course, the registered nurse came twice a week—I mean, every 2 weeks, unless we called her for something, and that was Debbie Rowe, and she would come whenever we called her. In fact, I would call her at home sometimes, too. She was excellent. She was a very, very good nurse.

Ms. WUNDER. There was a statement made about patients being discharged from the hospital as fast as possible. My father has heart disease. He has lymphoma. He has kidney failure. He is a double amputee. He has circulatory problems. He has had numerous strokes and even so—his platelet count is very low. He would be transported to the hospital in an ambulance for a transfusion. They would keep him overnight or at the most 2 days and immediately send him back home. If we had not had the public health nurse come at that point——

Ms. PATRIZIO. We couldn't have done it. He would have been in a nursing home maybe a year ago, I would say 6 or 7 months ago.

Incidentally, he is at Russell Park Manor and I really think they are very, very good. I always find him clean and the nurses and the aides seem to be very considerate and if I ask them something, they will tell me. In fact, they even showed me his body to show how nice it was. So he wasn't full of sores or nothing like that. I really think they are doing a very, very good job.

Ms. SNOWE. That is very essential.

Ms. PATRIZIO. I think they are doing a very good job. But as far as my husband, he has been in and out of the hospital since 1968. In fact, he had a blood clot on the aorta and they had to take that out before they even amputated, and he had to have 16 pints of blood, and he was in intensive care for 3 weeks. She was in the Philippines with three little children and the doctor said, you better get her over here, he is not going to live. That was in 1968 and he is still here.

Ms. SNOWE. That is wonderful.

Ms. PATRIZIO. But he was also a very, very active man. He went up until a year and a half ago he was out in the garage splitting logs in the wheelchair. Always very busy.

Ms. SNOWE. I appreciate you telling your story.

Ms. PATRIZIO. We are glad to help because we did get very, very good service—I don't know what I would have done without them. I couldn't have handled it. We would have had to sell the house by now.

Ms. SNOWE. Ms. Atkinson, how did you first learn of home health care services? Were you referred by a physician to receive home health care?

Ms. ATKINSON. I was referrerd by a physician because I was in the hospital and out so many times they lost track. Furthermore, I wanted to add something that I notice is not on here. I have a permanent setup for oxyen.

Ms. SNOWE. Do you administer that yourself or do you have somebody assist you?

Ms. ATKINSON. I have tanks that I carry with me if I have to go out anyplace and I also—those tanks can be refilled from the big tanks that I have at home. I wear the oxygen mostly at night. When I am lying down, I find that I get more congested.

Ms. SNOWE. What kind of home health assistance do you receive and how often?

Ms. ATKINSON. Androscoggin Home Health and they show up there—there are three of them. The nurse comes twice a month, once to take blood work, and once just for a general checkup. Then I have a girl who comes in and bathes me and she comes twice week. I also have a woman who does some cooking for me. She is from the Great Falls outfit, which is another branch, and for this I—it cost me $153 a month for her, besides what they pay.

Ms. SNOWE. What would you have done if you were not able to receive these home health care services; what would have been your alternative?

Ms. ATKINSON. My alternative probably would have been a nursing home and there probably would have been a riot there.

Ms. SNOWE. I don't blame you. You mentioned in your testimony that your physician recommended that you go out with your wheel chair?

Ms. ATKINSON. That is right. He said I was cooped up all last winter. I never went out of the house. Early this spring I got my wheelchair, and he said, as soon as you can use it, you get out and see some people. Otherwise, you will be going right up a wall.

Ms. SNOWE. So you are able to get out on occasion?

Ms. ATKINSON. So I do get out on occasion, not too often. But I guess in the last 3 months I have been out twice.

Ms. SNOWE. How long have you received home health care?

Ms. ATKINSON. Oh, gracious. My memory doesn't go back that far.

Ms. SNOWE. I guess it serves you well, then?

Ms. ATKINSON. I have had it quite a while because I was in and out of the hospital, in and out of the hospital, in and out of the hospital and every time I was out of the hospital, I had a home health aide.

Ms. SNOWE. You had no problem getting it between hospitalizations?

Ms. ATKINSON. No.

Ms. SNOWE. That is great. I thank you very much for your testimony and I thank you for making a tremendous effort to get here today. I certainly appreciate it. It is very important to get the prespective of those who receive home health care.

Ms. ATKINSON. You have got a darned nice bunch of girls in there.

Ms. SNOWE. Ms. Russell, you mentioned in your testimony on page 6 that it is very apparent that Medicare coverage of home health services is being billed to the Medicaid Program. Are you saying that the services that otherwise should be reimbursed under the Medicare system are not? Is that——

Ms. RUSSELL. I think under the system of appeals it would be paid for by the Medicare Program, but——

Ms. SNOWE. Are individuals reluctant to take their cases to appeal?

Ms. RUSSELL. I think it is easier to get it paid through Medicaid.

Ms. SNOWE. They avoid going through the hassles of the appeals process and get services through Medicaid. Is that what you are saying?

Ms. RUSSELL. Uh-huh.

Ms. SNOWE. Who do you think should represent the beneficiaries in an appeals case? I know the providers aren't able to, at this point, based upon changes in the regulations, but do you think that the providers should represent the beneficiary in an appeals case?

Ms. RUSSELL. I think that is what this LAMP association is all about, that they would be the person that represents the appeal. I am sure R aine can answer that questions more specific than I can. They are in this 24 hours a day, but it just seems that it is—these are sort of like road blocks in people's way and they are dehumanizing, for one thing, and they are just receiving little bits and pieces that make it more restrictive and more difficult for people to receive the care that they need.

Ms. SNOWE. You mentioned in your testimony about an 80-year-old woman who had 20 different caregivers. Why was that the case, do you know?

Ms. RUSSELL. Well, because I think the turnover rate is so great in the personal care system, they have no benefits.

These girls that are employed, they are self-employed, and they have no access to the group health insurance or unemployment benefits and those things, and they are not paid that well. It is a dead-end kind of a job, not much prestige to it. And I think if they can go to college and get an extra 50 cents or $1 an hour, they can do it because it has more appeal in itself.

Ms. SNOWE. In your position with the Maine Committee on Aging, what has been your experience with individuals who want home health care, but are unable to receive it? Do you receive numerous complaints or inquiries concerning home health care or the fact that they are not reimbursable services, given their individual situations?

Ms. RUSSELL. Well, I think at this point the Home Based Care Program has expanded a bit so that they are beginning to be able to serve more people. Previously there has been a waiting list. All the areas have a waiting list for people who want the services but they are unable to provide it for various reasons. Either the money is not there or I think now they have a problem trying to find the workers, the personal care assistants, to do that kind of work.

Ms. SNOWE. Is it also because the State has been very innovative in their own Home Based Care Program and has picked up the slack?

Ms. RUSSELL. That the services are better you mean?

Ms. SNOWE. Yes.

Ms. RUSSELL. Much.

Ms. SNOWE. So that has probably alleviated some of the pressures here in this State?

Ms. RUSSELL. Greatly.

Ms. SNOWE. So even with the changes in the medicare regulations concerning home health care, given the fact that the State has been creative and innovative in their program and policies, it has probably eased the pressures for the need for home health care?

Ms. RUSSELL. I think the program has never been fully expanded because it has had limited funds. It has never even been advertised. A lot of people don't even know what it is and it has been in existence since 1979. And I think that a lot of that is because they haven't been able to advertise it and a lot of people just—you hear about it through word of mouth.

Ms. SNOWE. I have been involved with the medicare patients' bill of rights which informs patients of their rights when they are hospitalized. Now, particularly in light of the prospective payment system in hospitals, do you think we should establish the same type of process for home health beneficiaries to inform them of their right to appeal?

Ms. RUSSELL. I think they should be involved in their right of appeal, but I don't think they need to know about their bill of rights. I think the appeals process should be advertised and explained, and I think they should be included from the checks and they certainly have correspondence with all these people all the time. I think they should certainly be able to slip in a little note to tell them about the appeals process and some of the availabilities.

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Ms. SNOWE. Finally, you mentioned our ombudsman program in the State and I think the State has taken the lead in this country with respect to that program. How do you envision it working?

Ms. RUSSELL. Well, I think the same way that it works with the nursing homes, that it would answer complaints from the families, the clients themselves, or from an agency that was going in to help give care. That would be the entry complaint and these complaints are followed up carefully, documented and this legislation—the recent legislation gave the ombudsman the right to go into the home.

I think they felt the need was there. I think people who only have one copy of their bills, of their—and a homebound person does not have access to a copying machine to have a copy made, so when they have to spend their bill in for a denial of payments or for some questions, they have to return the original; then they have no record.

Well, the way the Government proceeds is usually they delay 2 or 3 months and they lose the original and they ask the people to send another copy and they don't have a copy. I was wondering if the Government could send two copies, one for them to lose, and one for the person to use.

Ms. SNOWE. I thank you all very much. You have been excellent witnesses and I think you gave us a tremendous introduction to this hearing and to the value of home health care to individuals, such as yourself, yes, and to other people in this State. So I thank you very much for taking the time and making the effort to be here today.

Thank you.

[Recess.]

Ms. SNOWE. We will now have the second panel. I am pleased to have such a distinguished panel of experts who can address the issues we want to raise on the second panel, since we have already heard firsthand what home health care essentially is.

In the second panel we are honored to have Miss Betsy Perry, the director of the Androscoggin Home Health Aid, and the president of Home Care Alliance of Maine. She will be addressing some of the problems that home health care providers have been facing as a result of changes in Medicare.

Our second witness, Ms. Gail Wright is director of the Bureau of Maine Elderly. She is in charge of the aging programs in the State of Maine which are funded by the Administration on Aging under the Older Americans Act. She is also administration of other funds which are then coordinated through the area agencies on aging statewide.

Our third witness is Miss Trish Riley. Trish is the director of the Bureau of Medical Services, and among other things is responsible for the quality, control, and licensing of home health agencies. She has been involved with aging programs for a long time in the State of Maine, as well as nationally.

So I welcome our three panelists here this morning. I appreciate the fact that you are here to give up your testimony and your perspective on home health care here in the State of Maine, as well as nationally. Why don't we begin with you, Betsy.

PANEL TWO—HOME HEALTH CARE PROVIDERS: CONSISTING OF BETSY PERRY, PRESIDENT, HOME CARE ALLIANCE OF MAINE, AND DIRECTOR, ANDROSCOGGIN HOME HEALTH AGENCY; PATRICIA RILEY, DIRECTOR, BUREAU OF MEDICAL SERVICES, DEPARTMENT OF HUMAN SERVICES; AND GAIL DRAKE WRIGHT, DIRECTOR, BUREAU OF MAINE'S ELDERLY, MAINE DEPARTMENT OF HUMAN SERVICES

STATEMENT OF BETSY PERRY

Ms. PERRY. Thank you very much, Representative Snowe. I am very pleased to have this opportunity to share with you some of the problems in the supply side of home health care and to give you the providers' viewpoint.

Most of the people who know me who are in this audience know that I try to look on the bright side of things, but these days when I talk about the Medicare home health benefit, other than some of the wonderful things you heard from the Patrizios and Mrs. Atkinson this morning, there are not a whole lot of bright things to talk about.

This is really the most discouraging time since 1965 when the Medicare home health care benefit began. It is discouraging for providers, but even more discouraging for beneficiaries. They don't know if they are covered for services, for how long, and what to do if benefits run out. In our Government's attempts at savings in health care, they have chosen the smallest program least likely to have a strong Washington lobby.

The Home Health Program and beneficiaries are among the faintest of voices when they speak. We must speak louder and more often just as we are doing today. The saddest irony of all is that the random attacks on the home health benefit have caused paperwork burdens for both the providers and the government which, in turn, has contributed to rising costs. The inefficiencies in the Federal management of the home health program are inexcusable during these last few years.

It is high time for Congress to take a good hard look at the program and how it fits within the entire Medicare system. A closer look at several reimbursement and coverage issues will demonstrate the severe, random, and sometimes unfair cutbacks.

The first issue has to do with cost limits. Current regulation requires that home health agencies must settle costs at their fiscal year end on a discipline-by-discipline basis. This is a change over the last year. On an aggregate basis the vast majority of home health agencies in Maine had no problems with the cost caps, that is, they were below the cost caps. On a per discipline basis, Maine agencies are faced with the problems of low volume services in very rural areas, which is usually the case of those services exceeding the caps, necessitating that the provider subsidize the services or eliminate them. Let's take a look at one example and what it has meant for patients of Androscoggin, Oxford, and Franklin Counties.

Providing occupational therapy services over a 4,300-square-mile area is extremely costly due to distances between patients, time spent in travel there, and the scarcity of occupational therapists to

meet the demand for services. The need is there. The supply is not there.

The Medicare cost limit for 1986 for an occupational therapy visit in this area is $53.69. At the end of 1985, the Medicare costs of Androscoggin home health services for providing occupational therapy was $67.10, well above the cost cap. Our board of directors had to make a tough decision and voted that we would no longer directly provide Medicare occupational therepy services because it was too costly. What is doubly frustrating is that the agency cannot benefit from other discipline areas in which we are below the cost caps.

As an example, our home health aid current cost is $21.03 per visit. The cap is $34.15 per visit. The cost is well below the cap. If the agency could share even at a small percentage in the difference between our costs and the limits, we could use this difference to subsidize occupational therapy services and again offer them in the tricounty area.

A second issue has to do with the now infamous Gramm-Rudman-Hollings Deficit Reduction Act. Home health agencies will receive a 1-percent across-the-board reduction in reimbursement at the year-end cost settlement if Congress cannot meet its deficit reduction requirements.

This does not sound like it would have any major impact, particularly given that Medicare providers were exempted from the 4.3 percent cuts across the board. But most Medicare providers are not cost reimbursed as are home health agencies. The end result is that no matter how much we cut staff, administrative costs will still only be reimbursed at 99 percent of our costs. So there will be no savings to the Medicare Program.

What we will be doing is cutting services and still subsidizing the medicare program by 1 percent on all costs. Where does this money come from? In the past most home health agencies here in Maine have relied on municipal funding and United Way funding to help subsidize services. Since the towns themselves are faced with cutbacks, we don't know where the money is going to come from.

A third issue is what is called a waiver of liability, and pardon me if I get a little technical, but I would like to share this. The waiver of liability is a presumption that providers act in good faith when judging whether services to a patient would be covered. In other words, we have to thoroughly understand the benefits and make appropriate decisions in setting up patient care plans to make sure that whatever services we provide are covered by Medicare. The waiver of liability allows a 2.5 percent margin of error and who can be right 100 percent of the time? Certainly we cannot.

If 2.5 percent of an agency's visits in any given quarter are not covered—are not considered by Medicare to be covered, they would be paid, regardless of denial, by Medicare reviewers. This small, but equitable and workable margin of error serves as a safeguard. It keeps us on our toes because we do not want to lose the waiver.

What is wrong with this safeguard? The administration in Washington has made repeated attempts to eliminate the presumption of waiver since they feel it provides payments for services that were not covered and would save millions of Medicare dollars.

In a time of tremendous change in Medicare rules and regulations, and with increased demand for home health services, providers need this margin of error as they attempt to adjust and often psych out the changes since guidelines and instructions are often late and unclear.

A fourth issue that signifies unfair cutbacks in Medicare is the issue of prompt payment of claims. In the summer of 1985, just a year ago, many of the Maine home health agencies began to see a pattern of rapidly increasing accounts receivable for Medicare claims. In other words, the claims were presented, the payment wasn't coming.

The fiscal intermediary initially denied any action to delay payments, but it became clear very soon that it was another administrative mandate from Washington to slow the processing of Medicare claims and, therefore, slow down the outflow of funds from the Medicare trust fund, in the hope of gaining higher interest returns on those funds.

In the meantime, many home health agencies found themselves unable to make their payrolls or pay their staff without looking to local banks to borrow money due them from the Government. Just recently a letter from one home health agency to the fiscal intermediary, and this was in August, tells of having received 500 denied visits over a 4-week period.

In the last 2½ years, this particular agency had an excellent record and had lost their 2.5 percent waiver margin only twice. Why all of a sudden so many denied visits and loss of the waiver? The verdict is still out. But the facts point to what appears to be a sweeping of the decks of old claims unpaid in the medical review department of the fiscal intermediary. Because 8 percent of the denied visits date back to the last quarter of 1985, nearly 20 percent are 6-month-old claims, 12 percent 5-month-old claims, and 35 percent 4 months old. The agency in this case is forced into a costly position of having to appeal most of the denials.

An estimate of just this week is that already they have spent $2,000 in staff time around these denied visits. If you take 500 visits into $2,000, it is costing them $4 a visit to appeal these visits. Already 200 of the 500 have been reversed in favor of the beneficiaries. What kind of an effective system of claims review and processing is this?

Let's take a look at barriers, and coordination of services. As patients are admitted to home health agencies sicker and quicker, many of them have a need for additional services not covered by Medicare, but covered by another insurer or by the family itself.

Both Mrs. Atkinson and the Patrizios are examples. With no basis in statute or regulation, Medicare reviewers across the country have denied Medicare services on the basis that, if the patient needs more than what Medicare will pay for, then the patient doesn't meet the intermittent or part-time eligibility requirement under Medicare. That is, they are sicker than what Medicare the home health benefit was intended to pay.

Who are the losers in these cases? Patients lose out on the needed services and family members lose who are trying to keep the patients out of the institutions. The provider loses out because

payment for these services are not made since the denials do not come under the waiver.

Two coverage issues I would like to speak about. The home bound requirement. Mrs. Atkinson talked about this. Under current guidelines homebound means a normal inability to leave home, and consequently leaving home would be a considerably taxing effort, as we have seen in her case today. This is reasonable and home health agencies have lived with this for years.

However, medical reviewers over the past year have chosen to interpret homebound as meaning bedbound. For example, a patient who was recently denied Medicare services because she was not homebound needed the home health help of two people in order to leave her house. The denial was appealed and immediately reversed. The reviewers stated in the Medicare office that if the patient could walk more than 20 feet, with or without help, then there would be an automatic denial.

Another patient was denied visits due to not being homebound. He needed a catheter change once a month. The reviewer suggested he go to the physician's office instead of having the nurse go out to the house. The patient would have had to be transported by ambulance to the physician's office. Which option is cost-effective health care?

Let's take a look at skill level and frequency of visits. As the Patrizios have pointed out, as Mr. Patrizio's health status declined and he needed more services, Medicare was cutting back. Part of this reason is that as a result of the chronicity of his health problem, the skill level needed was, in the eyes of Medicare, less.

What is happening is that for many of the health home agency's professional staff, nurses and therapists, their decisions in consultation with physicians around patient care, are being subjected to harsh and sometimes demeaning questioning by medical reviewers who, of course, have never seen the patient.

Take, for example, a newly diagnosed diabetic who needed teaching and assessment of what turned out to be an 80-pound weight loss. Visits were limited in this case to a total of three over a very short period, since, in the words of the reviewers, if a patient cannot learn that quickly about his disease, then Medicare shouldn't waste its funds on them any longer. The man was subsequently hospitalized.

The same motion about teaching is being denied to terminally ill patients. That is, two or three visits are enough for teaching the patient and family about the care. Interestingly enough, studies of increasing health care costs show hospital care for the terminally ill is one of the major reasons for escalating costs. Declaring a patient not skilled is very arbitrary and puts the professional in a guessing game, with the rules unknown to the providers. Is this fair? Does it really save money?

One final example of Medicare nonsense relates to the coverage for intravenous medications at home. In the hospital Medicare will cover IV, intravenous medications, but it will not do so for patients at home. Consequently, many patients receiving courses of antibiotics for various infections must remain in the hospital at an expense of at least $400 per day when the patient could be safely cared for

at home at an average of around $100 a day covering several nursing visits.

One patient of ours wanted so desperately to go home for his 6-week course of antibiotic treatment that he was willing to use his $6,000 in life savings to pay out of pocket for the medications. This is very sad and unfair.

With all of this going on in the Medicare home health program, why do not patients come forward in droves to tell about these denials? We have already heard some of the reasons why. Medicare has removed the right of providers to represent these patients in their appeals. How likely is it that a recuperating person whose Medicare rights are so vague and unclear to begin with will appeal a coverage decision without assistance?

In January of this year the administration in Washington announced a new requirement that, upon admission to a hospital, a Medicare patient must be informed of his or her right to appeal.

In most States very nice explanatory pamphlets were developed to inform the hospital patient of their rights and indeed this was done in Maine. Does this require anything for home health care beneficiaries? No. As we have already learned, it should.

What can be done about these tightening screws, the ratcheting down and the increasing number of losers, both beneficiaries and providers? The answers are not simple. But one basic approach would be for the administration to play by the already existing set of rules, that is, not changing regulations without following legal and proper procedures. And to issue clear interpretive guidelines until they can develop a workable new prospective pay system for the home health benefits.

In the now pending budget reconciliation legislation in both the House and Senate, there are a number of home care provisions which would protect and clarify the home health benefits under Medicare. Passage of these provisions is absolutely essential. Congress has begun to take note of the plight of the home health beneficiaries and providers. We are very grateful for their support and action. I hope all of us have not acted too little too late, however. The future must be attended to, as well as the correction of these past mistakes.

A few ideas for the future improvement of the Medicare home health benefits include, first, development and testing of prior authorization of services as an alternative to the waiver of liability. This wouldn't eliminate the 2.5 percent margin of error as the administration would like, but it would give some clearer guidelines for the home health agencies in providing services.

Second, there should be a strengthening of the definition of intermittent care to allow for Medicare daily visits if they are indeed keeping the patient out of a hospital.

Third, families should be allowed to augment the Medicare services with services covered by other insurers or themselves. This augmentation is often the key to postponement of more costly institutional care as the Patrizios pointed out.

Fourth, there should be allowance for the coverage of intravenous medications as a home health benefit.

And finally, there should be development and enactment very soon of a prospective payment program for home health to encour-

age true management efficiencies by the home health agencies and to provide some rewards for the same.

On behalf of the Home Care Alliance of Maine, I thank you so much for the opportunity to share our concerns and ideas for strengthening a small, but most important Federal program. As you know, we are ready, willing, and able to offer our assistance in any way that you, Representative Snowe, one of our key decision-makers, can identify.

[The prepared statement of Ms. Perry follows:]

PREPARED STATEMENT OF BETSY PERRY, PRESIDENT, HOME CARE ALLIANCE OF MAINE; AND, DIRECTOR, ANDROSCOGGIN HOME HEALTH AGENCY

Are the Federal Medicare Program cost-control efforts tightening the wrong screws on the backs of the elderly and poor? The collective experience of the Medicare-certified home health agencies in Maine would say "yes". On a daily basis, home health agencies, hospital discharge planners, and case managers struggle with questions of what to do for the safe and humane care of many Maine elderly and poor. Will Medicare or Medicaid pay? For how long? Can the family pick up where Medicare leaves off? What interpretive changes in benefits have occurred this week? Will these costs be reimbursed under Medicare? These are but a few of the concerns of providers as they take on the responsibilities invested in them by the Medicare Program as certified providers. Each of these concerns affects the supply of home health care in Maine as well as the rest of the Nation.

In 1965, home health benefits were included in the original Medicare law for the purpose of providing older persons who meet the home health coverage requirements with reasonable and necessary covered services as ordered by a physician. Congress intended that home health services would improve the Medicare Program's cost efficiencies by enabling older persons to be cared for appropriately at home rather than in a hospital or nursing home. With Medicare costs zooming from $4.7 billion in 1967 to $64.6 billion in 1984, it was Medicare's turn to be targeted for cost controls by Congress and the Reagan Administration. On April 20, 1983, President Reagan signed into law the prospective payment program for hospitals after a very brief four months from time of introduction into Congress. Screws had been tightened with the passage of this legislation without knowing the effects on Medicare beneficiaries and non-hospital providers. Unfortunately, some wrong screws have been and continue to be tightened without the concomitant adjustments in other parts of the Medicare Program. Let's take a closer look at the home health benefit and what appears to be a concerted effort by the Federal government to curtail what, how much, and when beneficiaries will receive services that were once covered under the very same basic regulations that exist today.

Right from the start, the Medicare home health benefit is very limited in who and what it covers. Of the 31 million Medicare beneficiaries in 1985, only about 1.2 million used the home health benefit across the Nation. Medicare home health expenditures nationwide are about three percent of the total Medicare expenditures.

Eligibility rules for beneficiaries restrict usage of benefits as seen in the above statistics. The home health candidate must pass through four major barriers before becoming eligible for services. First, the patient must require skilled care, that is be sick enough for the services of a registered nurse, physical therapist, or speech therapist, while at the same time have rehabilitation potential. Secondly, the patient must require skilled care on a part-time basis only, that is not be too sick. Thirdly, the patient must be homebound, that is require the assistance of a walker, wheelchair, or another person to ambulate. Finally, the patient's services as ordered by the physician must be medically reasonable and necessary in the eyes of Medicare reviewers. Medicare-certified agencies learned to live with these rules over the years since 1965, with occasional disagreements over any one of the four areas of eligibility.

In 1983, each and every one of the Maine certified agencies began experiencing what now has become known as the "attempted dismantling of the Medicare home health benefit". Clear signals of constraints and outright exclusion of previously covered services began happening nationwide. Providers were taken by surprise, and beneficiaries as a whole had and still have little or no idea why they may be sent home from a hospital without nursing services or why their home health agency must say their services are no longer covered in spite of still recuperating and needing the services. Why has this happened?

Federal officials say cutbacks in the Medicare home health benefits were necessary since it was the fastest growing portion of Medicare expenditures, that is it jumped from $1 billion in 1980 to a projected $2 billion in 1986. However, it was the Federal government itself that paved the way for this growth through the enactment of the prospective payment system in hospitals and through allowing proprietary home health providers to become certified in states without home health licensure laws. Also contributing to the growth in home health expenditures was inflation and the ever-rising number of elderly persons in our society. Is this growth bad? The actions of the Federal government would certainly indicate a resounding yes as they continue their relentless march to narrow and confine the home health benefit. The victims of this march are the elderly here in Maine and elsewhere. Let's take a closer look.

Right now, Maine certified home health agencies are experiencing five major attacks on reimbursement which limit the services available for Medicare beneficiaries. In addition, there are two coverage issues and one appeals issue which also whittle away at the home health benefit. Let's look at each one of these more closely:

1) Home Health Agency Cost Limits

Current regulation requires that home health agencies must settle costs at year end on a discipline-by-discipline basis

and not on aggregate visit cost as has been the requirement for years. The Federal Register notice in May, 1985, announcing this change stated that the Administration expected some home health agencies to "change their behavior", and some would "eventually choose to cease providing services to Medicare beneficiaries." What did this mean for certified agencies in Maine? On an aggregate basis, the vast majority of home health agencies had no problems with the cost caps, that is, visit costs fell below the aggregate of the cost caps. On a per discipline basis, Maine agencies were faced with the problem of low-volume services being very costly and exceeding the caps necessitating the agency to subsidize the service or eliminate it. Let's take a look at one example and what it has meant for patients in Androscoggin, Oxford, and Franklin Counties. Providing occupational therapy services over a 4,300 square mile area is extremely costly due to distances between patients, time spent in travel, and the scarcity of occupational therapists to meet the demand for services. The Medicare cost limit for 1986 is $53.69 per visit, and our Medicare cost per occupational therapy visit at year end in 1985 was $67.10. Our Board of Directors had to make a tough decision and voted that we would no longer provide Medicare occupational therapy services. What is doubly frustrating is that the Agency cannot benefit from the other discipline areas in which we are well below the visit caps. As an example, our home health aide current cost is $21.03 per visit, and the cap is $34.15 per visit. If the Agency could share even at a small percentage in the difference between our costs and the limits, we could use the difference to subsidize occupational therapy services. BUT. . . as the Federal Administration had hoped for, they have indeed changed our behavior, and we have ceased to deliver occupational therapy services. Who in Washington cares about the patients?

2) Gramm-Rudman-Hollings Deficit Reduction Act

Home health agencies will receive a one percent across-the-board reduction in reimbursement at year-end cost settlement if the Congress cannot meet its deficit reduction requirements. Big deal, you might say. Medicare providers were exempted from the 4.3 percent cuts, but most Medicare providers are not cost reimbursed as are Medicare home health agencies. The end result of this one percent below cost reimbursement may mean that a number of the Maine agencies will be running a deficit solely due to this reduction with few, if any, options to make up the deficit. As one of our Congressional delegates has written, "I am sympathetic to the case which you present, but am afraid that I cannot be too encouraging about the possibility of a further exemption from Gramm-Rudman-Hollings." Again, Washington has curtailed the expansion of home health lest it get out of control.

3) Waiver of Liability

The waiver of liability is a presumption that providers act in good faith when judging whether services to a patient would be covered. It allows the agency a 2.5 percent margin of error in making these judgements such that if 2.5 percent of an agency's visits in any given quarter are not considered by Medicare to be covered, they would be paid regardless of denial by Medicare reviewers. This small, but equitable and workable margin of error serves as a safeguard against oversupply of Medicare services. What is wrong with this safeguard? The Administration has made repeated attempts to eliminate the presumption of waiver since they feel it provides payment for services that were not covered and would save millions of Medicare dollars. In a time of tremendous change in Medicare rules and regulations and with increased demand for home health services, providers need this margin of error as they attempt to adjust and often have to "psyche out" the changes since guidelines and instructions are often late and unclear.

4) Prompt Payment of Claims

In the Summer of 1985, many of the Maine home health agencies began to see a pattern of rapidly increasing accounts receivable for Medicare claims. The fiscal intermediary initially denied any action to delay payments; but it became clear that it was another Administrative mandate to slow the processing of Medicare claims and, therefore, the outflow of funds from Medicare hoping for higher interest returns on those funds. In the meantime, many home health agencies found themselves unable to make payrolls without turning to local banks to borrow money due them from the government. One agency's accounts receivable increased by 50 percent in just four short months from $600,000 to over $900,000, so even a $200,000 line of credit from a local bank was not enough to maintain cash flow as well as increased demand for home health services. Let's look at another example of the effect of late payments of claims. A letter dated August 21, 1986 to the fiscal intermediary in Maine, tells of one agency having received 500 denied visits over a four-week period. In the last two and one-half years, this agency had lost their waiver only twice, an excellent record. Why all of a sudden so many denied visits and loss of the waiver? The verdict is still out, but facts point to what appears to be a "sweeping of the decks" of old claims in the medical review department of the fiscal intermediary. Eight percent of the denied visits date back to the last quarter of 1985, 19.5 percent are six months old, 12 percent five months old, 35 percent four months old, 6.5 percent three months old, and 4.3 percent two months old. The agency is forced into a costly position of having to appeal most of the denials. What kind of an effective system of claims review and processing is this?

5) Barriers to Coordination of Services

As patients are admitted to home health agencies sicker and quicker, many of them have a need for additional services not covered by Medicare, but covered by another insurer or the family itself. With no basis in statute or regulation, Medicare reviewers have denied the Medicare services on the basis that if the patient needs more than what Medicare will pay for, then the patient does not meet the intermittent or part-time eligibility requirement under Medicare. Who are the losers in these cases? The patient loses out on much needed services and may have to be institutionalized, and the provider loses out on payment for services since denials of this nature are not waiver eligible.

These five reimbursement issues are evidence of tightening screws that are hurting beneficiaries and home health providers. It is a very discouraging time to be a Medicare provider, but even more discouraging to be a Medicare beneficiary not knowing what is covered for services, for how long, and what to do if benefits run out. In our government's attempts at savings in health care, they have chosen the smallest program least likely to have a strong Washington lobby for major attack. The home health program and beneficiaries are among the faintest of voices when they speak. We must speak louder and more often. The saddest irony of all is that the random attacks on the home health benefit have caused paperwork burdens for both the providers and the Federal government which, in turn, have contributed to rising costs. The inefficiencies in the Federal management of the home health program are inexcusable during these last few years. It is high time for Congress to take a good hard look at the program and how it fits within the entire Medicare system. A closer look at two coverage issues will demonstrate even more tightening.

1) The Homebound Requirement

Under current "guidelines", homebound means "a normal inability to leave home and consequently, leaving home would be a considerable and taxing effort." This is reasonable; however, medical reviewers chose to interpret the interpretation as meaning bedbound. For example, a patient, recently denied Medicare services because she was not homebound, needed the help of two people in order to leave her house. The denial was appealed and immediately reversed. The reviewer stated that if the patient could walk more than 20 feet with or without help, then there would be an automatic denial. Another patient was denied visits due to not being homebound. He needed a catheter change every month, and the reviewer said he should go to the physician's office instead of having one nursing visit per month for a catheter change. The patient would have had to be transported by ambulance to the physician's office. Which option is cost-effective health care?

2) Skill Level and Frequency of Visits

Many of the home health agency professionals are finding that their nursing and therapy decisions in consultation with physicians are subjected to harsh and demeaning questioning by medical reviewers who, of course, have never seen the patient. Take for example a newly diagnosed diabetic who needed teaching and assessment of what turned out to be an 80-pound weight loss. Visits were limited to three since in the words of the reviewer, "if a patient can't learn that quickly, then Medicare shouldn't waste its funds on them any longer." The man was subsequently hospitalized. The same notion about teaching is being applied to terminally ill patients, that is, two to three visits are enough for teaching the patient and family about care. Interestingly enough, studies about increasing health care costs show that hospital care of the terminally ill is one of the major reasons for escalating costs. Declaring a patient not skilled is very arbitrary and puts the professional in a guessing game with the rules unknown to the providers. Is this fair? Does this really same money?

One final example of Medicare nonsense relates to the coverage for intravenous medications at home. In the hospital, Medicare will cover the I.V. medications but will not do so at home. Consequently, many patients receiving courses of antibiotics must remain in the hospital at an expense of at least $400 per day just for the room without the cost of medications, when the patient could be safely treated at home for an average of around $100 per day for the nursing visits. One patient wanted so desperately to go home for his six-week course of treatment that he was willing to use his $6,000 in life savings to pay out-of-pocket for the medications. This is so very sad.

With all of this going on in the Medicare home health program, why do patients not come forward in droves to tell about these denials? Medicare removed the right of providers to represent patients in their appeals. How likely is it that a recuperating person whose Medicare rights are so vague and unclear to begin with will appeal a coverage decision without assistance? In January of this year, the Administration in Washington announced a new requirement that upon admission to a hospital, a Medicare patient must be informed of his or her rights to appeal a coverage decision. In most states, explanatory pamphlets were developed to inform the hospital patients of their rights. Does this requirement exist for home health beneficiaries? No.

What can be done about the tightening screws, the ratcheting down, and the increasing number of losers - both beneficiaries and providers? The answers are not simple, but one basic approach would be for the Administration to play by the existing set of rules, not changing them without following legal and proper procedures, and to issue clear interpretive guidelines

until they can develop a workable new system of home health benefits. A look at current legislation related to home health supports this notion.

In the now pending budget reconciliation legislation in both the House and Senate, there are a number of home care provisions which would protect and clarify the home health benefit under Medicare. Passage of these provisions is essential. The Senate Finance Committee provisions allow for aggregation of visit costs and cost limits beginning on or after October 1, 1986, and the House Energy and Commerce Committee would restore the aggregation retroactively to July 1, 1985. Regarding prompt payment of claims, both the Senate Finance Committee and the House Ways and Means Committee have requirements for the payment of "clean" claims (ones not needing any adjustments) within 24 and 22 days respectively. Provider representation of beneficiaries in appeals and expansion of the waiver of liability to include homebound and intermittent denials are included in both the Senate Finance Committee package as well as House Ways and Means.

Additional bills which bear full consideration in Congress are the House and Senate versions of a Medicare Quality Protection Act. These bills, if passed, would exempt cost-reimbursed providers from the automatic one percent Medicare cuts. None of our Congressional delegates here in Maine hold out much hope for their passage in view of the ominous deficits in the entire Federal budget.

A final piece of legislation in the Senate that would serve to protect the home health benefit is S. 2492, the Medicare Home Health Improvement Act, cosponsored by Senator George Mitchell. This legislation would prevent the Administration from bypassing the regulatory change process which allows a thorough review of the changes by Congress and the general public. Secondly, the bill prohibits the Administration from establishing separate cost limits and requires them to use recent data (rather than three-year-old data) in determining the cost limits for home health services. As a major step towards better care for patients in the transition from institution to home, the bill mandates discharge planning for all inpatients and ambulatory surgery outpatients. These provisions were included in the Senate Finance Committee version of the budget reconciliation bill adopted on July 23, 1986.

Congress has begun to take note of the plight of the home health beneficiaries and providers. We are grateful for this support and action. I hope all of us have not acted too little, too late. The future must be attended to as well as the correction of past mistakes. A few ideas for the future improvement of the Medicare home health benefit include:

1) Development and testing of the effectiveness of prior authorization of services as an alternative to the waiver of liability provision.

2) Strengthening of the definition of intermittent care to allow for Medicare daily visits if they are keeping the patient out of an institution.

3) Allowing families to augment the Medicare services with services covered by other insurers or themselves. This augmentation is often the key to postponement of more costly institutional care.

4) Allowing for coverage of intravenous medications as a home health benefit.

5) Development and enactment of a tested and widely accepted prospective payment program for home health to encourage true management efficiencies and rewards for the same.

On behalf of the Home Care Alliance of Maine, I thank you so much for the opportunity to share our concerns and ideas for strengthening a most important Federal program. We are ready, willing, and able to offer our assistance in any way that you, as a key decision-maker, may identify.

Ms. SNOWE. Thank you. Those are some excellent recommendations for alternatives to the existing regulations and for improving the home health care program without creating additional hardships. We will get to questions at the end of the statements of our other two witnesses.

Trish.

STATEMENT OF PATRICIA RILEY

Ms. RILEY. I come from a different perspective, having moved from the Bureau of Maine's Elderly to the Medicare Program. Because it follows the Medicare Program, I ask you to—beg you to change the program so that Medicaid can be more flexible so I can be a better advocate.

Let me begin by reflecting back on a very recent conference we had in Maine about new technology. During that conference it was noted that in Great Britain public policy limits who can receive the benefits of technological advances, such as, kidney dialysis. People were shocked and horrified at the conference to think that rationing of health care exists. But I must question our own public policy here in the United States.

Here the Federal Government has announced that Medicare will begin paying for heart transplants. Yet, here in this country, we are doing the exact opposite of Great Britain. We are not rationing high technology. Instead, we are rationing home care. While heart transplants may be a wonderful and important expenditure, the cold hard truth remains that only about 3 percent of the total expenditures in the Medicare Program are spent on home care each year. I suspect if you ask the older people in this room today or in any place around the country where they would want new resources spent, they would make the tough, hard choice to spend it on home care and not new technology. Yet our Government appears not to be listening.

Similarly, the Government is spending enormous staff resources within the Health Care Financing Administration on investigating new methods of attacking the problem of catastrophic illness. The preliminary census came from Secretary Brown regarding catastrophic illness. Frankly, it frightens me. In those early discussions, and perhaps they have changed since those early discussions, the Secretary was proposing a system that would help people pay for extended hospital care. It suggested levying an increased premium on every single Medicare beneficiary.

Beneficiaries have already been hit with changing deductibles and copayments. Now it is being suggested that each of them pay for expanded hospital care for about 12 percent of the population. Again, I wonder why we are looking at high-technology and catastrophic illness, not that they are not important, but, in times of difficult cost decisions, why are those the decisions the Government is making when you hear the compelling stories about people who need home care? I think the Congress unfortunately has to act and ask the Federal Government some real tough questions.

It is probably important to reflect on the beginnings of the Medicare Program in 1965. In those days when one looks at how that program came to be established, one recognizes quickly that it was

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the concerns of physicians and other medical professionals, and not the consumers, that really structured this program. It, therefore, provided financing for hospitals, physicians, and some very limited acute health care services. It is very much a medical program. Those are essential services for older people, but they surely are not enough.

Again, I think that the expansion of catastrophic illness coverage and high technology reflect that same bias. It is just too limited for what people need. Since the Health Care Financing Administration of the U.S. Government administers both the Medicare and Medicaid Programs, and since Medicaid is a tiny program compared to Medicare, it is not surprising that HCFA uses the federally administered Medicare Program as a model for setting policy for State-administered Medicaid programs.

However, Medicaid is supposed to be a program administered in a partnership with State government and, therefore, forcing it to mirror Medicare further limits State flexibility. There are several administrative changes we think are crucial.

The first and most obvious, and I won't go into detail, is the homebound rule. But it does strike me, listening to Laurel, and the others, this morning, the Medicare has denied the profound fundamental right of selfhood in that it really creates disincentives for Laurel Atkinson and people like her to do the things that all of us take for granted. Simply getting out of her house and being the independent soul that she has always been, makes her ineligible. She is quite right. She is running the risk of losing her benefits.

Second, the program must allow for the provision of lower cost maintenance services, such as expanded occupational, physical therapy, personal care assistance, not just the skilled kind of care provided by nurses and physician services.

Third, the definition of intermittent care must be changed. It must allow for blocks of service of several hours several times a week. Presently the program tends to allow only short-term visits. It disallows agencies from providing longer term needed services and billing for them by the hour or in blocks of several hours' time. Again the program fails to understand the maintenance needs of the chronically ill.

Fourth, eliminate the requirement that the physician must order and sign the plan. Most physicians are not aware of the individual's environment and home setting, while home health nurses and area agency state managers are. Physicians are crucial elements of care, of course, and should continue to order strictly medical services.

Fifth, allow Medicaid more State discretion. Consistency with Medicare would be ideal and would help us make this fragmented system a bit more whole until Medicaid changes, and I don't have a great deal of hope for rapid change. This current inconsistency constricts the State's ability to make our Medicare Program look more like a home based care model.

Sixth, amend the medicaid waiver of liability provision. This provision, and Betsy spoke eloquently to it, reflects on Medicaid, so let me try to expand on it a bit.

This provision causes hardship to local agencies and the State in trying to respond to the needs of the home health care clients. If a

home health agency bills Medicare for a service which Medicare has denied in the past, or the agency suspects Medicare will deny, the intermediary may then review each and every plan that agency has submitted. This slows down payments considerably and invites agencies to be gun shy and not submit any claims, but rather bill other payors. Since Medicaid must be the payor of last resort, we cannot pay a bill until every other source has been exhausted. We find ourselves in a conflict with our home health agency as we must insist they bill Medicare before we can pay a claim. And, if we don't do that, we get a nonexception on our Medicare Program.

More difficult are the reported inconsistencies in what Medicare will and will not pay for. Agencies report that a service paid for 1 month will be denied the next for no apparent reason.

Medicare denial of claims has increased dramatically, and as a direct result the burden of those costs has shifted to the State, and most particularly to the State Medicaid Program. We see an alarming increase of claims submitted to Medicaid which state "Not Covered by Medicare." This may be because Medicare views its service as maintenance and not skilled, because the client is not homebound or simply because the agency has been denied for a similar care plan in the past and was reluctant to process another, fearing the waiver of a liability auditor, as Betsy explained.

From January 1986 to June 1986, just 6 months, Medicaid paid $1.1 million for home health service provided to Medicare-eligible clients. That will be over $2 million this year. We believe a significant portion of these costs ought to have been borne by Medicare. I quickly point out that the State share of that $2 million would fund enormous numbers of home health visits the home care visits and might better be spent that way. Also, as Margaret Russell mentioned, when people deny themselves care, they become sicker before they get care, and that increases—and you see this increase—inappropriate use of hospitals, and more high technology services, be they nursing homes, hospitals, or emergency rooms. In the Medicaid Program we see a growing and inappropriate use of emergency rooms, and that is a very costly care provider. Therefore, our costs go up and up simply because another system isn't working.

Medicare's influence is seen in other ways in Medicaid. Presently, HCFA states that Medicaid cannot exceed Medicare's upper limits of reimbursment. Since Medicare bills for home health visits, which are usually brief, Medicaid generally must do the same in our routine home health services, although we believe there are deficiencies in billing hourly which exceed a typical visit. That is, many frail elderly need more than a short visit, as Laura pointed out, four times more than somebody else who comes in. Yet, Medicare fequently won't pay for that block of time.

Since I began my discussion speaking about high technology, let me conclude on that same topic. Expanding home care requires increased availability of durable medical equipment, such as wheelchairs and walkers. Medicare pays for much of this, but Medicaid pays for the co-insurance of individuals who are eligible for both Medicaid and Medicare. That is about 20 percent of the Medicare-allowed payment. Medicare historically paid based on past charges of durable medical equipment, thus creating an incentive for high

charges. If a provider knows Medicare will pay a percentage of whatever his charge has been, there is little motivation to restrict that charge.

Admittedly, Medicare at this point is paying for 2-year-old charges, but still they have that incentive for inflation built into the system. Simply, there are few restraints on equipment, and we have found equipment rented to individuals for a period of time which far exceeds what it would have cost to purchase that equipment; yet, Medicare pays for the long-term rental and Medicaid is forced to pick up the growing costs.

These costs are not incidental and represent an area of potential cost savings to Medicare. While we have not broken down our data to show how many we pay in coinsurance specifically for durable, rentable equipment, we do know that costs for the service element are growing rapidly. In just 2 years, from 1984 to 1986, again years of rapid growth in our home field system, Medicaid recipients receiving durable equipment have nearly doubled, from 3,500 to 5,200, and our costs have grown from $1.3 million to $2.3 million in Maine alone.

In general, I would simply reflect on Betsy's comments and the kind of action that she urged, although I must say, putting on my bureaucratic hat, that I am shocked to hear providers suggest that prior approval is a good idea and one would have to come to the Government first before providing service. My heart leaped up. That is when I knew Betsy was very angry and very frustrated.

And let me suggest that I think we ought to have a system we can rely on. Prior approval costs the Government money because you need to hire bureaucrats that do the prior approval. And, frankly, it is a time-consuming process no matter how well and how effectively it is done by hard-working bureaucrats.

The fact of the matter is, it delays, and people who need the service are going to be sitting there waiting. It may be an improvement to the system today, which is pretty depressing; but there must be a better way.

Ms. SNOWE. Thank you.

STATEMENT OF GAIL DRAKE WRIGHT

Ms. WRIGHT. I want to thank you for the opportunity to be here today.

I first want to have a brief discussion about the impact of the restrictive Medicare reimbursement policy, because we have heard everyone else testify on this so far.

The home health services benefit under part A and part B of the Medicare Program faces a coverage squeeze because of restrictive interpretation which is having a detrimental impact on home health care providers—I think Betsy talked about that—other State and federally funded programs, and, most of all, elderly people themselves.

While Medicare home health care coverage has the potential of providing competent medical care for individuals in need of home health services, the rigid interpretations of the regulations and the adherence to nonbinding guidelines by intermediaries and HCFA have severely limited access to Medicare-funded home health serv-

ices. The capacity of providers to offer the services is affected for needed home health care to elderly individuals.

These restrictions in reimbursement imposed by Medicare also have resulted in a shift in the cost and liability to State-funded programs and to individual beneficiaries. One State program which is so affected is the Home-Based Care Program which, as you know, resulted from legislation passed in Maine in 1981, which was entitled "* * * an Act to Provide In-Home and Community Support Services to Adults with Long-Term Care Needs."

Approximately 25 percent of Maine's total home-based care dollars are used for the purchase of skilled nursing and home health aide services. Many of the clients receiving these services have been denied Medicare-funded home health care. Using scarce home-based care dollars to replace Medicare reduces the potential funds available for other services, such as homemakers, transportation, personal care assistance, adult day care, and all the other more flexible services that could be provided under our State home-based care program.

This shift is occurring at a time when the increased demand on our home-based care program is also reflecting a larger annual cost per client, a cost that has gone from, in 1984, $1,245 to, in 1986, $1,874. Elderly individuals who are not frail enough to qualify for State-funded home-based care, yet who need home health services, have limited options. They may go without the service. They may pay out of pocket or exhaust their resources to a point where they are eligible for Medicaid.

Cost-shifting is also occurring with our federally funded programs. The Bureau of Maine's Elderly, as you know, receives Federal funds for nutrition and social services under title III of the Older Americans Act. While funds for title III have remained relatively stable, at approximately $1.2 million per year since 1981, they have been increasingly diverted to support long-term care services. In 1981, 7.2 precent of this Federal allocation was spent on care management for in-home community-based services. In 1985, 45 percent of the same allocation went to care management. This diversion of the title III funds has meant a decrease in money available for transportation, outreach, handyman, and home repair services, and the friendly visitor program, and a neglect of our own title III. We strongly believe that the core program for elderly persons under the Older Americans Act cannot be the permanent sacrifice for our vitally important comprehensive case management system for in-home community-based services.

Because of the restrictive coverage and the denials of claims for home health services under Medicare, care managers in area agencies on aging report to us they often find themselves in a difficult and frustrating position. Their responsibility is to develop a care plan that meets the needs of their client. The necessary services may include those which are, in theory, covered by Medicare. Yet, they cannot pursue that Medicare coverage because of Medicare's restrictive reimbursement policy. This can put the care managers in a difficult position, the same position Trish was alluding to with respect to the Medicare agency, with the home health agencies, since the home health agencies are ultimately responsible for petitioning for the Medicare-covered services, yet cannot afford to jeop-

ardize their waiver of liability by pursuing claims they know will be denied.

This results in tension within our home care system in Maine that can potentially compromise the coordinated and comprehensive long-term care service system and the advocacy mandate of the Area Agencies on Aging. In the State of Maine, the aging network has demonstrated its capacity to serve as planner and advocate for in-home services. It has successfully improved and extended the availability of services from Maine's aging population.

Recognizing both the need for alternatives to nursing home care and a clear preference on the part of the elderly persons to remain at home, the Bureau of Maine's Elderly and the AAA's have developed a system of services that can allow frail elderly people to maintain themselves at home.

Since 1981, the Home-Based Care Program has served over 4,000 individuals who were at risk of institutionalization in nursing homes. The intent of this program is to maximize the available resources and to provide a plan of care for each client that will delay or avoid the need for institutional care.

The Bureau of Maine's Elderly, the Area Agencies on Aging, and the Maine Committee on Aging, have coordinated their efforts to build systems of care to respond to the gaps and deficits in home health care provided by Medicare and Medicaid.

With limited State resources, the aging network has provided a local solution based on the needs of Maine's elderly system. The aging network in Maine identified care management as a focal point that would assess the elderly person's needs, develop a plan of care, and coordinate the services so that limited resources are used efficiently and effectively.

The area agencies, as someone earlier pointed out, also perform assessments of clients seeking nursing home placement and assessments under the Medicaid Alternative Long-Term Program. Maine also runs a Medicaid Waiver Program. The waiver, which was first received in 1985, is similar to those in existence in other States. This waiver program further extends the availability of home care services to the frail elderly population at risk of institutionalization and who are without adequate means to pay the services.

Despite many accomplishments in the advocacy effort that have expanded the options and accessibility of in-home services for the elderly population, Maine's aging network has limited resources. As the population of persons over age 85 grows, demand for home health services will grow exponentially.

Even with the success of the Home-Based Care Program and our effort increasing from that program, the State cannot support the deficit in home care imposed by Medicare restrictions and denials. The aging network in Maine cannot effectively solve the problems caused by a Federal entitlement program which is supposedly available to virtually all elderly persons, in spite of our best advocacy effort.

The aging network must and will continue in its planning and advocacy role to advocate for increased services for the at-home, frail eldely, supported by both Federal, State, and private funds; to advocate for a flexible and coordinated system of home care that accommodates the full range of needs of homebound elderly indi-

viduals; an adequate supply of qualified staff for home health services; and an increase in pay and benefits for these workers that will attract qualified persons and also ensure that supply.

I also would like to mention briefly Maine's newly-funded Medicare Advocacy Program. Margaret Russell also alluded to this in her testimony. Our program is modeled after the successful initiative in Connecticut, and is a joint effort of the Bureau of Medical Services, Bureau of Maine's Elderly, Committee on Aging, and our nonprofit Legal Services, providing legal services for the elderly.

One focus of this program will be to represent persons who are eligible for both Medicare and Medicaid, and for whom Medicare has denied services and the costs have been shifted to Medicare. The objective will be to obtain rightful Medicare coverage.

Another focus will be to provide the same advocacy to persons who are eligible for both medicaid and Medicare and have been denied the service by Medicare. We estimate that 20 percent of the more than 200 dual eligible claims per month now paid by Medicaid may warrant Medicare appeal.

For those individuals who are eligible for Medicare, but can't qualify for Medicaid, the program has the potential to keep them from spending their own resources on care that has been previously denied by Medicare. For others who have had to forego these health services when Medicare has refused coverage, the needed services may finally be available to them through Medicare.

It is our hope that this program will both reduce cost shifting and enable more persons to receive the services to which they are entitled. It is important to point out, though, that this is an example of having to appeal what may have been an unnecessary appeal to begin with if some of the other problems and interpretations of regulations were solved.

In closing, I would just like to say that my remarks this morning have focused on the effects of Medicare's restricted reimbursement policies on the programs that we administer at the Bureau of Maine's Elderly. As Director of the State Unit on Aging, my concerns about the Medicare program do go beyond home health services. As a health care financing mechanism, Medicare is biased toward short-term institutional care.

In the acute care setting, Medicare covers 84 percent of hospital costs of the elderly. By contrast, Medicare covers only about 2 percent of chronic care costs for the elderly and then only for short-term bouts of acute episodes.

Many elderly persons have no choice but to impoverish themselves in order to qualify for Medicaid funding for long-term care services. In order to provide a quality system of long-term care services for elderly persons, and one that gives them the option of remaining at home and in the community as long as they desire and as long as it is possible for them, we must develop new models for the financing of chronic care services.

This process should include the reexamination of the role of the Medicare program in a coordinated public-private approach to long-term care.

Thank you very, very much for the opportunity to speak.

[The prepared statement of Ms. Wright follows:]

PREPARED STATEMENT OF GAIL DRAKE WRIGHT, DIRECTOR, BUREAU OF MAINE'S ELDERLY, MAINE DEPARTMENT OF HUMAN SERVICES

Good morning. I am Gail Drake Wright, Director of the Bureau of Maine's Elderly. I am here today to speak about the supply of home health care in Maine. My comments will address three issues:

I. How changes in the Medicare reimbursement policy for home health services have affected programs administered by the Bureau of Maine's Elderly;

II. the role of the aging network in planning and advocacy for home health services; and

III. the anticipated effect of our newly funded legal assistance program to advocate for Medicare benefits.

I will first turn to a discussion of the impact of restrictive Medicare reimbursement policies. The home health services benefit, under Part A and B of the Medicare program, faces a coverage squeeze because of restrictive interpretation which is having a detrimental impact on home health care providers, other state and federally funded programs and, most of all, elderly people themselves.

Medicare home health coverage has the potential of providing comprehensive medical care for the individual in need of skilled nursing care, medical social services, physical, occupational, or speech therapy or home health aide services. But, the rigid interpretations of the regulations and adherence to nonbinding guidelines by the fiscal intermediaries and HCFA have severely limited access to Medicare funded home health services. The capacity of providers to offer services is affected and needed home healthcare to elderly individuals is jeopardized.

The restrictions in reimbursement imposed by Medicare also have resulted in a shift of costs and liability to state funded programs and to individual beneficiaries.

Approximately 25% of Maine's total Home Based Care dollars are used for the purchase of skilled nursing and home health aide services. Many of the clients receiving these services have been denied Medicare funded home health care. Using scarce home based care dollars to replace Medicare reduces the potential funds available for services such as homemakers, transportation,

personal care assistants, adult day care, respite, home delivered meals and chore services. Also indicative of the increased demand on the HBC program is the increase in the average annual cost per client over the past three years. In 1984, the cost was $1245, and, in 1986, the cost had risen to $1874.

Elderly individuals who are not frail enough to qualify for State funded home based care, yet who need home health service, have limited options. They may go without services, pay out of pocket or exhaust their resources to a point where they are eligible for Medicaid.

The Bureau of Maine's Elderly receives federal funds for nutrition and social services under Title III of the Older Americans Act. While funds for Title III have remained relatively stable, at approximately $1.2 million per year since 1981, they have been increasingly diverted to support long term care services. In 1981, 7.2% of this allocation was spent on care management; in 1985, over 45% of the same allocation went to care management. This diversion of Title III funds has meant a decrease in money available for transportation, outreach, handyman-home repair services, and the friendly visitor program. We strongly believe that the core program for elderly persons under the Older Americans Act cannot be the permanent sacrifice for our comprehensive case management system for in home and community services.

Because of the restrictive coverage and the denials of claims for home health services under Medicare, care managers in area agencies on aging often find themselves in a difficult and frustrating position. Their responsibility is to develop a care plan that meets the needs of their client. The necessary services may include those which are, in theory, covered by Medicare. Yet they cannot pursue that Medicare coverage because of Medicare's restrictive reimbursement policy. This can put the care manager in a difficult position with the home health agencies, since the home health agencies are ultimately responsible for petitioning for the Medicare covered services yet, cannot affort to jeopardize their waiver of liability by pursuing claims they know will be denied. This results in tension within our home care system in Maine that can potentially compromise the coordinated and comprehensive long term care service system and the advocacy mandate of the area agencies on aging.

The restrictive interpretations of Medicare coverage also have resulted in many elderly people purchasing Medigap insurance policies. Expecting that these policies will pay for home health and chronic care services, some consumers buy several policies, which only duplicates the coverage they already have under Medicare. The restrict-

ions and denials imposed by the Medicare program over the past several years have further exacerbated the concerns of the elderly consumer about the adequacy of the Medicare program. We have noted a growing tendency for elderly persons motivated by fear of non coverage by Medicare, to use scarce resources for a very limited health care insurance product.

II. The second issue I want to discuss is the role of the aging network in planning and advocacy for home health services. In the State of Maine, the aging network has demonstrated its capacity to serve as planner and advocate for in-home services. It has successfully improved and extended the availability of services for Maine's aging population.

Recognizing both the need for alternatives to nursing home care and a clear preference on the part of elderly people to remain at home, the Bureau of Maine's Elderly and the AAA's have developed a system of services that allows frail elderly people to maintain themselves at home.

An Act to Provide In-Home and Community Support Services for Adults With Long Term Care Needs (popularly known as the Home Based Care Act) was passed by the Maine Legislature in 1981. Since then, the program has served over 4,000 individuals who were at risk of institutionalization in nursing or boarding homes. The Act required home based care program dollars to be dollars of last resort, only paying for needed services not otherwise covered by other funding sources. The dollars enable an elderly individual to access services such as home health care, homemaker, transportation, personal care assistance, adult day services, respite care, home delivered meals and chore and escort services. The intent of the Program is to maximize the available resources and to provide a plan of care for each client that will delay or avoid the need for institutional care.

The Bureau of Maine's Elderly, the area agencies on aging, and the Maine Committee on Aging have coordinated their efforts to build systems of care to respond to the gaps and deficits in home health services provided by Medicare and Medicaid. With limited state resources, the aging network has provided a local solution, based on the needs of Maine's elderly citizens. They have gained the support of the legislature and the Governor for their endeavors.

The aging network in Maine identified care management as a "focal point" that would assess the elderly person's needs, develop a plan of care and coordinate the services so that limited resources are used efficiently and effectively. The area agencies also perform assessments of clients seeking nursing home placement and services under

the Medicaid Alternate Long Term Care Program.

Another unique component of Maine's home and community based services program are the Quality Assurance Review Committees. Quality Assurance Review Committees were established in 1981 as part of the home based care program to monitor the adequacy and appropriateness of client services. Committees in each region, composed of community, provider, and consumer representatives offer a particular knowledge of local needs and a crossection of expertise in their review. They now also provide a monitoring function to the state's Medicaid Waiver program.

The Medicaid waiver, granted in 1985, is similar to those in existence in other states. It further extends the availability of home care services to the frail elderly population at risk of institutionalization who are without adequate means to pay for services. It does not replace Maine's state-funded Home Based Care program, but instead provides a needed alternative for those individuals who are financially (and medically) eligible for care in a nursing facility but were previously over the income criteria for Title XIX if residing in their own homes.

Despite many accomplishments that have expanded the options and accessibility of in-home services for the elderly population, Maine's aging network has limited resources. As the percentage of the population over age 85 grows, demand for home health services will grow exponentially. In Maine, our Older American Act resources have been tapped to their limit; we cannot allocate any more Title III money to care management or in-home services. Already, other Title III mandates have been neglected because of the shift in funding allocations. Even with the success of the home based care program, the state cannot support the deficit in home care imposed by Medicare restrictions and denials. The aging network in Maine cannot effectively solve the problems caused by a federal entitlement program which is supposedly available to virtually all elderly Americans.

The aging network will continue to advocate for:

- increased services for the at-home frail elderly, supported by federal, state, and private funds.
- a flexible system of at-home care that accommodates the full range of needs of the homebound elderly individual.
- an adequate supply of qualified staff for home health services.
- an increase in pay and benefits for these workers that will attract qualified personnel and ensure that supply.

III. The third area of discussion relates to Maine's Medicare Advocacy program. The State of Maine is initiating a Medicare advocacy program, modeled after a successful initiative in Connecticut.

In September 1985 a study of Maine's Medicare decisions was initiated by the Maine Committee on Aging and undertaken by Legal Assistance to Medicare Patients, (LAMP) of Willimantic, CT to determine the feasibility of a Medicare advocacy program in Maine. The study concluded that:

a. Medicare-coverable home health services are being billed to Medicaid because of pressure by the fiscal intermediary to limit payment and because of restrictive interpretations placed on Medicare coverage guidelines.

b. In the absence of Medicaid eligibility, home health agencies in Maine are shifting Medicare-coverable expenses to the Home Based Care program.

c. In the absence of available Medicaid coverage or Home Based Care payments, patients are receiving less care than is reasonable or necessary to meet their medical needs at home.

The Medicare advocacy program is a joint effort by the Bureau of Medical Services, Bureau of Maine's Elderly, the Maine Committee on Aging and Legal Services for the Elderly who is Maine's non-profit legal service provider to elderly persons.

One focus of the program will be to represent persons who are eligible for both Medicare and Medicaid and for whom Medicare has denied services and the costs have been shifted to Medicaid. The objective will be to obtain rightful Medicare coverage. Another focus will be to provide this same advocacy effort to persons who are eligible only for Medicare and have been denied service coverage by Medicare. Individual representation, impact litigation and broad based advocacy efforts are contemplated. It is hoped that the program will garner support from home health care providers and elderly programs who are so greatly affected by Medicare's restrictive policies. The program will also provide a strong effort in community and provider education.

We estimate that 20% of the more than 200 dual eligible claims per month now paid by Medicaid may warrant Medicare appeal. Assuming an average of $1500 per case in Medicare benefits that may ultimately be reclaimed, the state will collect several hundred thousand dollars that can be used to defray the costs of the Medicaid program.

For the beneficiaries, the Medicare advocacy program will assure them the benefits under Medicare to which they are entitled. For those individuals who are eligible for Medicare and not poor enough to qualify for Medicaid, the program has the potential to keep them from spending their own resources for care that has been previously denied by Medicare, thus for some, preventing pauperization. For others who have had to forego these health services when Medicare has refused coverage, the needed services may finally be available to them through Medicare. This population of elderly persons in Maine is extensive. One third of Maine's elderly are completely dependent on Social Security; another 32% depend on Social Security for more than one half their income; and the average Social Security income in 1980 was only $3,934. These people stand to benefit a great deal from a program of Medicare advocacy.

My remarks this morning have focused on the effects of Medicare's restrictive reimbursement policies for home health services. As director of the State Unit on Aging, my concerns about the Medicare program go beyond home health services. As a health care financing mechanism, Medicare is based toward short-term, institutional care. In the acute care setting, Medicare covers 84% of hospital costs for the elderly. By contrast, Medicare covers only 2% of chronic care costs for the elderly and then only for short-term, post-acute episodes. Many elderly persons have no choice but to impoverish themselves in order to qualify for Medicaid-funded long term care services.

In order to provide a quality system of long term care services for elderly persons and one that gives them the option of remaining at home and in the community as long as they desire and is possible, we must develop new models for the financing and delivery of chronic care services. This process should include a re-examination of the role of the Medicare program in a coordinated, public-private approach to long term care.

Thank you for the opportunity to speak on an issue of great concern to elderly persons in Maine.

Ms. SNOWE. Thank you for your outstanding testimony.

And, to all of you, I think you raised a number of issues, as well as highlighted a number of problems that exist with the changes in the Medicare system that unquestionably affect the ability to provide home health care in this State and across the country. I have a number of questions, and I will try to pare them down.

To start off with, it is my impression—and I gather it is your impression—that the changes in the regulations by HCFA encourage institutionalization rather than discouraging it. Further, it seems to me that the changes in interpretation really discourage individuals from seeking out home health care or continuing it on a long-term basis. Is that your impression with these reimbursement changes, for instance with the definition of homebound and intermittent care, and so on? Do you understand the rationale for that?

Ms. PERRY. I just want to give some recent trends that we have seen in 1986 as compared to 1985. In our own agency, Androscoggin Home Health Services, we have both decreasing numbers of Medicare visits per admission and Medicare patients, but we have increasing numbers of cases opened. In other words, what is happening is a Medicare patient comes, is admitted to our agency, they are discharged sooner because of the more stringent requirements, but they are admitted more often.

They tend to go back into the hospital, get bounced out of the hospital, back into the home health care system, fewer visits. This trend is being seen more and more.

The other trend is exactly what Gail, Margaret, and Trish have spoken about—the shift from Medicare to Medicaid. While we have the decreasing Medicare patients, we have increasing Medicaid patients.

Ms. SNOWE. Well, do you see that as an intentional shift?

Ms. RILEY. It is still a federally run program. I guess the difference is that the Medicaid Program, in Maine, is roughly only 70 percent federally funded. States have a bigger share. We have seen increasing efforts by the Federal Government asking the States to pick up more and more of the share of Federal resources.

So I would have to say yes. It is all in the name of partnership. Maybe if we got more flexibility with that partnership, it would not be more difficult. I think that is part of the administration's philosophy, and we see that.

Ms. SNOWE. What is your definition of "homebound"? How do you determine eligibility based on that definition because that is obviously a very difficult definition. As you have said, HCFA has a tendency to mean bedbound given the way they define homebound.

Ms. PERRY. We try to use the HCFA written interpretation and guidelines for homebound. There was a letter of clarification on that a number of months ago, if not a year or so ago now, and that is the one that I mentioned in my testimony of a normal inability to be home and that the individual must have the assistance of a person or a walker or something like that.

What we find is there is no consistency in the application of that definition. So while our staff used that in making judgments or interpretations of the patient's situation, there will be a request for additional information or a denial based on homebound—lack of homebound status; when, in fact, the staff person has documented

that there is a need for assistance and a fairly extensive need for assistance.

So it becomes a guessing game. We don't know what the reviewers have recently been told or where they are headed with some of the decisions that they make. We try to stick with what we have in writing.

Ms. RILEY. It is just a catch 22, and it is the same problem statewide by other Medicaid directors who have begun to complain about the same issues of cost shifting and who is going to do what. They talk about different interpretations by region.

But the curious thing is that they are tightening up the definition of homebound to be bedbound, which means to me that what they are saying is we want to serve a very frail population. When I think in terms of the tough economics we are facing, I can understand why they are doing that. Nevertheless, they haven't changed the service elements they are providing for. They have, on the one hand, changed the client they are serving, while on the other hand, they still provide short-term intermittent care, the kind of old-fashioned public health nursing notion that too many still carry with us. The person is sick, you help them, you leave and they are all better.

Ms. SNOWE. So, obviously, the clients are sicker and they are not getting the kind of care they deserve. I guess I don't understand the rationale of limiting the amount of time. You mentioned Trish, in your testimony, that Medicare will not reimburse for a block of time.

Ms. RILEY. It's an acute care system that, again, is based on the traditional short term visits for an intermittent period of time. The visit rate is what is applied to Medicare and the visit tends to be—and that's where you get into the notion of what's a visit, and is it intermittent and is it part time? What we find is people need longer visits that don't meet the Medicare definition of intermittent. What they need is blocks of time, 4 hours, a chunk of time to help them out, and not just the short-term visit once a week.

Ms. SNOWE. What's defined as a short-term visit, 45 minutes or——

Ms. PERRY. Anywhere from 45 minutes to 3 hours.

Ms. SNOWE. That's maximum?

Ms. PERRY. It's not in writing, but it's a nationally accepted guideline by reviewers across the country, that if, say, a patient needs personal care, bathing, feeding, et cetera, that goes past a 3-hour block of time, then that person will be denied because it's chronic maintenance level care in the eyes of Medicare, and they will not pay.

Ms. RILEY. How many times a week do they do that?

Ms. PERRY. Very seldom. That's the other issue. If it's daily, it would be highly suspect because obviously this person needs more or is at a maintenance level of care and should be in a nursing home.

Ms. SNOWE. Under Medicare guidelines you cannot provide daily service or daily visits?

Ms. PERRY. We have been able to provide daily service for short periods of time. As Mrs. Patrizio pointed out, when we first visited her husband, we were visiting 7 days a week. That was cut back

fairly immediately. I think, in general, 2 weeks to 6 weeks, and it's reviewed fairly often in terms of daily coverage, but it could not go on over any extended period of time.

There is some legislation in Congress that tries to address this issue and would allow for more extended coverage of daily visits, as long as it indeed was keeping a patient out of the hospital.

Ms. SNOWE. You mentioned in your testimony, Betsy, that you had discontinued providing occupational therapy. Have you found that to be true with other health agencies in the State?

Ms. PERRY. Yes, some of them have faced the very same issues, and it's a complex problem. The occupational therapists are so scarce that they are very difficult to find and this drives up the cost of the services, because in order to attract an occupational therapist, particularly into rural areas, the salary must be very good and it's just so frustrating to have to do that.

One of the options we have is to hire an occupational therapist under contract which then means that we would not be providing benefits such as health benefits and some of the very basic benefits that people would like to have. So that means that, you know, the attractiveness of a salary and benefits are not there. So it makes it even more difficult to find OT's to work under a contract.

Ms. RILEY. And it again shifts to Medicaid. We have in our agency requests for occupational therapists, people looking for OT services and we are about to expand our OT coverage. It's probably a perfect example. I hadn't thought before why there's increased demand. The problem isn't everybody who is eligible for Medicaid—that's a tiny group—it is all those who would have been eligible for Medicare.

Ms. SNOWE. What happens if someone requires occupational therapy? What do they do under those circumstances when your agency, for example, does not provide occupational therapy?

Ms. PERRY. It can't be their sole service to start with. There have to be other nursing and physical therapy needs there, as well. Then there are options such as outpatient coverage or staying in the acute care setting or the rehab setting, or they go without it. There are certainly attempts by the nurses or anyone else who may be working with the patient to address some of the issues, but they can't be addressed as skillfully as by an occupational therapist. That's what's needed.

Ms. SNOWE. Have you found the denials by Medicare have increased substantially?

Ms. PERRY. Yes. All of the Maine agencies have found this to be true. In our home care alliance we have a reimbursement committee that has been following this very closely. And in the first 6 months of this year, there were about seven meetings around this issue and several meetings directly with the fiscal intermediary on the fact of increasing denials. And I gave you an example recently of one of the agencies that all of a sudden had 500 denials and it is just a costly problem to handle.

In the 6-month period of time from February 6, 1986 to July 1986 we had a total number of denials of around 57, and 32 of those were reversed. This is 47 percent of the denials we got were reversed, and so it means that almost half were indeed unnecessary denials. And that's very low. The estimate of the members of our

alliance which yesterday was about 12 agencies sitting together, is that close to 70 percent of the denials get reversed.

Ms. SNOWE. How long does that process take?

Ms. PERRY. A long time.

Ms. SNOWE. And they can go back at any time and look at your previous records; as you mentioned, they went back to 1985?

Ms. PERRY. These were claims that were still outstanding.

Ms. SNOWE. So they haven't been paid?

Ms. PERRY. They have not been paid and they were being looked at and denied.

Ms. SNOWE. And so in the process there's no defined period of time by which they have to make a decision on appeals or on the claim itself?

Ms. PERRY. There has not been.

Ms. SNOWE. I gather there's a discrepancy between what home health agencies are saying for the processing of claim payments and what the HCFA has been saying, that the average period of time is somewhere around 27 days of processing clean claims.

Ms. PERRY. But they decide what's a clean claim and we don't always know what they are calling a clean claim.

Ms. SNOWE. How do you make a decision as to whether a client is eligible? How do you make the judgment between whether that person needs skilled care or unskilled care and whether or not the case is on the threshold as to what might be eligible under Medicare? Do you avoid those cases? Do you deny them because you feel they are close to the threshold?

Ms. PERRY. It's a difficult situation to handle. What our staffs do throughout the agencies in Maine is to sit down with the patient and family and tell it as we are seeing it. In other words, it appears that if we visit in this case as the doctor has ordered, the denial will come after first visit, after third visit, after 2 weeks, whatever. And these are the other options and set forth the other options with the family, and then are very much included in the decision-making in terms of whether they go ahead. Once Medicare denies the visit, they can decide if they pay for the services from that point on or whether they look to their options, whatever they may need to be, such as bringing in private pay services or turning to one of the other State options. And very often, as it has been pointed out, there is coordination going on between the State programs and the Medicare programs.

Ms. SNOWE. So what is, in your opinion, the average length of time to process a claim, in your experience?

Ms. PERRY. It has—it has gone up and down so quickly over the last few—or the last year. It had been around 30 days up until the summer of 1985. And then it started getting to be 60 days, 90 days, and this was the point at which many of the agencies had to borrow money to make payrolls. What most of us did at that point was look into what is called the Periodic Interim Payment Program.

Things are getting very technical, I realize. There is a fund called PIP, and what this means is that the home health agencies get a regular monthly payment from Medicare that is based on the average amount of claims. I don't want to get technical because I don't know all the technical aspects of it, but it does mean that a

check comes in on a regular basis from Medicare which allows us at least to meet our ongoing demands in terms of payroll, et cetera.

Ms. SNOWE. Is there any documented increase in denials here in the State? Is there some evidence which you could submit to the record for increases in number of denied claims here in the State of Maine?

Ms. PERRY. Yes.

Ms. SNOWE. And also for any specific instances that might appear to be arbitrary?

Ms. PERRY. We can certainly do that.

[The following material was subsequently received:]

Home Care

Alliance of Maine

RECEIVED
OCT 13 1986
WASHINGTON, D.C.

October 9, 1986

The Honorable Olympia J. Snowe
Member of Congress
133 Cannon House Office Building
Washington, DC 20515

Dear Congresswoman Snowe:

As a follow up to your Congressional Hearing in Maine, "Home Care--Will it Be There When You Need It"; Betsy Perry, President of the Association, requested that the Reimbursement Committee of the Home Care Alliance of Maine accumulate some statistics regarding the denial crisis in Maine.

In Maine, we have approximately 16 Medicare certified home health agencies of which 13 are members of the Home Care Alliance of Maine. The agencies that are not involved in the enclosed statistics are either specialized service agencies, such as speech therapy, or ones that do not have the same fiscal intermediary (Medical Personnel Pool).

The future impact of the Medicare denials upon the elderly will be that "home care will not be there when you need it". The denial rates by visits is devastating financially to many of the non-profit agencies. For example, the 95 patient denials for Community Health and Counseling Services represents 777 visits; a potential loss of approximately $15,000. It is unreasonable to expect that no agency could survive that kind of financial impact for any length of time.

However, the greatest impact upon the elderly is that the professionals no longer have the confidence in their judgement that patients meet Medicare criteria and care will be denied expect to the critically ill patients.

The effect of the denials will be the removal of the "safety net" of home care to the elderly who are now being discharged earlier from hospitals due to D.R.G.

The average percentage of Medicare patients caseloads denied is 22% (the high of 63% and the low of 6% were not included), a very distrubingly high percentage for the Maine home health agencies for we cannot believe that our past history of compliance with Medicare regulations can now be wrong approximately one out of four times. Also, the 22% is suspiciously close to the 5:1 ratio that HCFA imposes upon the Fiscal Intermediary.

The Home Care Alliance of Maine requests your assistance in obtaining the HCFA guidelines that are in use by the Fiscal Intermediaries to re-interpret the Medicare regulations which home care agencies keep being told have not changed.

The recommendations for future legislation improvements to the Medicare home care benefits are:

(1) Defining intermittent care to allow for daily visits.
(2) Eliminating or re-defining homebound status.
(3) Allowing coverage of intravenous medications.
(4) Eliminating the 5 to 1 rule imposed on intermediaries.
(5) Maintaining aggregate costing verses per discipline costing.
(6) Research, development and testing of a prospective payment program.

The Home Care Alliance of Maine appreciates your support of home care and hopes that the enclosed statistics will be included with the other testimony of the September 4th Congressional Hearing.

Sincerely,

Helen Genco
Debbie Vilasuso

Helen Genco and
Debbie Vilasuso
Co-chairpersons, Reimbursement Committee

Enclosures

CC: Senator George J. Mitchell
Senator William S. Cohen
Senator John Heinz
Congressman John R. McKernan, Jr.
Governor Joseph E. Brennan
Trish Riley
Romain Turyn
Val J. Halamandaris
Members of the Home Care Alliance of Maine
Fred Howard
John Kennedy
Linda Billows
York County Health Association
Bob Leduc

MAINE HOME HEALTH CARE AGENCIES
STATISTICS ON DENIALS RECEIVED

1986

Agency	Number of Patients Denied August/September 1986	% of Medicare Caseload	Number of Patients Denied Jan 1 - July 31 1986	Reasons for Denials
Kennebunk Public Health Association	10	63%	0	(a) Not medically reasonable or necessary. (b) Duration.
Kno-Wal-Lin	23	15%	4	(a) Supportive/custodial care. (b) Not homebound. (c) Not skilled care.
South Portland Health Services, Inc.	12	32%	1	(a) Not homebound. (b) Not medically reasonable or necessary. (c) Duraction.
York County Health Association	69	19.2%	31	(a) Not homebound. (b) Not skilled. (c) Not medically reasonable or necessary.

Footnotes:

Agencies not included:

(1) Four Town Nursing Services, Blue Hill
- They have not submitted their billing to Medicare.

(2) Kennebec Valley

(3) Elaine R. Stevens Associates
- Specialized group.

(4) Medical Personnel Pool
- They have a different intermediary.

(5) First Allied Home Health

MAINE HOME HEALTH CARE AGENCIES
STATISTICS ON DENIALS RECEIVED

1986

Agency	Number of Patients Denied August/September 1986	% of Medicare Caseload	Number of Patients Denied Jan 1 - July 31 1986	Reasons for Denials
Androscoggin Home Health Care	20	6%	8	(a) Not reasonable or necessary. (b) Maintenance/Support-ive Care. (c) Not homebound.
Aroostook Home Care Agency	16	11.8%	25	(a) Not skilled. (b) Duration not on 485, block #12. (c) Not homebound. (d) Not reasonable or necessary.
Bangor District Nursing Association	27	19.5%	0	(a) Not medically necessary. (b) Not homebound. (c) Not skilled care.
Bay Region	2	16%	0	(a) Not homebound. (b) Not medically necessary or reasonable.
Community Health & Nursing Services of Brunswick	32	42.7%	8	(a) Not medically reasonable or necessary. (b) Not skilled care.
Community Health and Counseling	95	20%	17	(a) Technical denials. (b) Not medically necessary or reasonable. (c) Maintenance.
Community Health Services	66	19%	33	(a) Not medically necessary or reasonable. (b) Custodial. (c) Not homebound.

(Continued)

Ms. SNOWE. Gail, you mentioned in your testimony the Medicare Advocacy Program. When do you expect that to be operational?

Ms. WRIGHT. In the beginning stages in October of this year.

Ms. SNOWE. And what kind of assistance will be available?

Ms. Wright. To persons who would like to take advantage of the services, the program has several components to it. One part of it will be run by the Bureau of Medical Services through their third-party liability unit which will concentrate its effort on recouping dollars that Medicaid has paid that we feel should have been paid for by Medicare.

The independent advocacy part of this project— it is kind of one big project, but there are separate components of it which will be run by Legal Services for the Elderly. There will be a lot of input from the Committee of Aging. The program will be available in the same way that our entire legal services program is available to anyone who would like assistance, this will be available to an elderly person who would like assistance to process that claim.

Obviously, we hope that Legal Services for the Elderly will be doing a lot in partnership with the home health agencies, trying to identify places where we need to put some emphasis, individual claims that need to be pushed and also broader advocacy areas.

Ms. SNOWE. Well, individuals who are denied Medicare reimbursement, do they then go to Medicaid, or do you find sometimes they go to Medicaid without having been denied by Medicare?

Ms. RILEY. They do sometimes come to Medicaid and that is why we need to try this project. We do sometimes get a request to pay for a service that we think is Medicare eligible from agencies that have been, quite frankly, burned.

The advantage to the Medicaid Program—and again it is only a small percentage of the people—but it is that most poor people are eligible for both Medicare and Medicaid.

We can appeal the $1.1 million that we have spent in the last 6 months. Some of that we think should be appealed, and we can do that automatically on behalf of the client.

Medicaid can do that because the client signs off as a condition of Medicaid. So, for claims processing in those appeals, it may well be an easier and quicker process to get HCFA to discuss those cases.

Ms. SNOWE. So that you can represent them?

Ms. WRIGHT. Yes, those who are actually eligible.

Ms. SNOWE. Now, what about individuals who have been denied Medicare reimbursement? Will you be providing assistance?

Ms. WRIGHT. Legal Services for the Elderly will also be doing some of the dual eligible persons for both Medicare and Medicaid work, but concentrating the large measure of their efforts on the people who can't fall back on the Medicaid Program.

Some of the difficulty, of course, is identifying those people. But a lot of those people just simply go without the care that they need and don't necessarily think we ought to be pushing this further so some of the case findings that need to occur for the nondual eligible persons, and the public education, and coordination with the service providers is a real important part of that program.

Ms. SNOWE. Would there be a charge involved for this service?

Ms. WRIGHT. No.

Ms. SNOWE. And when will it be operational?

Ms. WRIGHT. In October. Legal Services for the Elderly is in the process of looking for staff at this time and it should be at least beginning in October.

Ms. SNOWE. I will ask you the same question I asked Margaret Russell concerning the representation of beneficiaries and appeals process. Do you think providers should be able to represent beneficiaries?

Ms. WRIGHT. I have thought about this question some and I am not sure whether it is my own background. I think a program—an advocacy program such as LAMP is in a very good position to be providing those services for beneficiaries.

I think some of the legal cases on this question—I think it is very—it is abominable the way HCFA has issued their ruling about the recent court case which has said a home health agency cannot be the representative.

To make that kind of decision without going through proper review and comment process, I think, is not a good one.

Frankly, I don't feel that I have enough experience in this system to say that it is necessarily a conflict of interest to put the home health agency in that position. I think there must be far and away many cases where home health agencies could be extremely beneficial to those beneficiaries who need that extra assistance in, first of all, making the decision to appeal, and I think they already have that support system in the provider agency.

I think there is a technical conflict of interest question that needs to be addressed. We can finesse that question in Maine because we will have the legal advocacy program that will be providing those services.

Ms. SNOWE. What has been your experience with DRG's? Are patients being discharged from the hospital sicker or is there a greater degree of illness with patients once they are discharged?

Ms. WRIGHT. I think everyone out there working with people feels very strongly, our care managers report that to be the case.

I think some of the increased costs in our Home Based Care Program, we think, are reflective of a number of things, increasing provider costs, people staying on the program longer, but also reflective of the fact that there are more complicated and complex and expensive plans of care for persons who are leaving the hospital in the early stages.

Ms. SNOWE. I have received a number of letters from individuals in my district in the State who have complained about being discharged too quickly and not receiving services or who have not been admitted and have had to rely on emergency room services as a result.

Ms. PERRY. Our nurses are finding that the level of care is much more skilled than it has been in the past years.

They are doing intravenous therapy at home, very complex dressings, and, of course, it is much more costly to do those kinds of things at home.

So at the same time we must make sure that we keep the skill level of our staff at the highest possible level so that the quality does not suffer.

Training—ongoing training costs are more, but at the same time—and this I didn't mention before—the cost caps for home health are going down. Not only are we having to settle on the discipline by discipline basis, but each year cost caps are slated to go down, so that while we are taking care of the sicker people, longer visits, more skilled care, the Government is saying, next year you will be reimbursed less than this year.

So it just feels like, you know, the walls are closing in on what we are doing.

Ms. SNOWE. Would you prefer to go back to the old system of reimbursing in the aggregate?

Ms. PERRY. Yes; absolutely, until there is some sort of prospective payment program.

Ms. SNOWE. Do you find there is an increasing need for institutionalized care in this State? Are there enough beds in nursing homes, for example?

Ms. RILEY. That is probably the single biggest controversy currently facing Maine. There certainly is enormous pressure on the home health care system. What kinds of services we need is unclear. What is absolutely clear is we need more long-term care service. What is absolutely clear is our nursing homes are very filled. they are serving sicker people.

How to solve the problem, I think, is something we really need to take a look at. It also relates to Medicare. Medicare does not pay for intermediate care facilities. In Maine, 9,000 of our total nursing home beds are intermediate care compared to 500 skilled beds.

Let's assume a Medicare person is admitted to the hospital and because of the DRG is asked to leave early. Chances are she won't be able to get that care, even though she has a benefit for it.

The industry today—and I hope to resolve it very quickly—is trying to convert some of our existing intermediate care facility beds to skilled beds to bring in more of that medicare resource. And, in fact, Maine's intermediate care facility meets a higher standard than the national standard.

We have good quality nursing homes that have higher standards of nursing staff. Many of those, because of the higher skill, can simply be converted to a skilled bed. The services are the same, the cost is the same. The staff is the same. But it brings in Medicare resources. Then we can address the problem of where to place those resources to get more long-term care.

Ms. SNOWE. You handled that very well.

Well, I am not going to detain you further, although I do have a number of other questions. But I do appreciate your thoughts and testimony here today. You have offered some excellent suggestions as to ways in which to improve the system, and very reasonable ones, I might add.

I think these are recommendations which should be addressed by Congress in order to avoid any further problems and any further erosion of the home-health care service, which obviously we can expect if we continue to go down this path.

Ms. RILEY. We should probably say something positive. HCFA has taken it on the chin; in fact, they have a very, very difficult job, which I sympathize with more and more in my present position.

The reality is they may have made changes in large measure because of what Congress has requested and the three of us are involved in home-based waivers.

They still have problems, but for the first time HCFA has provided major resources for home care. We are currently working with HCFA to develop a long-term program and to create more flexibility with our program and, frankly, they have been very helpful.

Ms. SNOWE. I appreciate it. Thank you all very much.

[Recess.]

Ms. SNOWE. In this third and last panel we will be addressing the issues raised in the first two panels with the administrative agents for Medicare home health benefits.

Mr. Howard is the vice president for Government Operations of the Maine Blue Cross/Blue Shield. This is the fiscal intermediary which is charged with processing claims for home health care in the State of Maine. As a result of consolidation of the number of intermediaries nationally, the Maine Blue Cross/Blue Shield will be taking on the claims processing for the entire New England region.

And, finally, Mr. John Kennedy, regional director of Health Care Financing Administration. Mr. Kennedy joins us today from Boston. His job is to oversee the implementation and develop guidelines to assist the intermediaries in performing their jobs. He is also a constant correspondent with my office as we seek to better understand the problems that we are discussing here today.

And it is nice to put a face with the name, Mr. Kennedy. I have signed many letters to you over the last few years, but I do appreciate your presence here—your taking the time and making the effort to come up from Bostom to address us this morning.

So why don't we begin with you.

PANEL THREE—HOME HEALTH CARE ADMINISTRATORS: CONSISTING OF JOHN KENNEDY, REGIONAL ADMINISTRATOR, REGION I, HEALTH CARE FINANCING ADMINISTRATION; AND FRED I. HOWARD, JR., VICE PRESIDENT, GOVERNMENT PROGRAMS, ASSOCIATED HOSPITAL SERVICE OF MAINE

STATEMENT OF JOHN KENNEDY

Mr. KENNEDY. Madam Congresswoman, first of all, let me express a word of appreciation for this invitation today and a word of compliment to you for the very excellent panels that preceded us here today.

It is always a pleasure to represent the government after panels with the expertise that preceded us, as you might imagine.

I have submitted official testimony for the record. I am prepared to make a summary of that and then to go on to address the four questions that you raised in your letter of August

Ms. SNOWE. I would appreciate that, Ken.

Mr. KENNEDY. What I would like to do is segregate the testimony into perhaps five compartments. I would like to provide a summary of background and statistics, and I might mention that these will be found on pages 1 and 2 of the testimony in the event that someone wants to follow along. Secondly, I will review the home health benefit itself. That will be on pages 2 through 5. Third, a brief dis-

cussion of the importance of the home health benefit in the context of general health care developments in this country. That is on pages 5 and 6.

Number four, I would like to spend some time discussing the steps that the Health Care Financing Administration has taken to improve, hopefully, the administration of the home health benefit. That is on pages 6 through 10.

And I will spend a brief moment in conclusion discussing some of the possible options for the future, particularly as they may relate to home health. Last, I will talk briefly about the four questions that you submitted.

Turning now to the background and statistics, I think it is a good point to begin the discussion as it relates to the Omnibus Reconciliation Act of 1980. That act made some very fundamental changes in the home health benefit. It eliminated a number of statutory provisions that tended to limit the scope of the benefit. For example, it removed the limit of 100 visits.

It eliminated the requirement of the prior hosital stay. It eliminated the deductible, and also permitted proprietary home health agencies to expand into the area of home health.

These changes resulted in what we perceive to be very substantial expansions in the home health benefits in terms of expenditures, in growth of services, and in growth of providers.

Expenditures, for example, doubled between 1980 and 1983, from $800 million to $1.6 billion. From 1983 to 1985 they almost doubled again from the $1.6 billion to $2.4 billion.

We estimate that by 1990 the home health expenditures under Medicare will rise to $4 billion. Visits and services have likewise grown from 1980 to 1984. They increased 78 percent, and visits in 1980 were only 1 million. Now in 1984, which is the latest official statistics that we are able to get, it is up to 1.5 million.

Providers likewise have grown. In 1980 we had only 2,900 providers. Today, 1986, we have 6,000 providers. We only had 165 proprietary agencies in 1980. We now have 2,000 proprietary agencies. Maine has 16 home health agencies, three of which are proprietary, and which served 7,600 of Maine's 167,000 Medicare enrollees in 1984. Likewise, Maine's home health expenditures have grown from $3.8 million to approximately $6 billion in 1985.

With respect to the second point, the home health benefit itself, much of the earlier testimony today, I think, brought into sharp focus the following. And I think it is important that that distinction be made if for no other reason than to assure you and the audience that we, in the administration of Medicare home health benefits, are attempting to do it in a responsible way consistent with what we perceive to have been the intent of the original legislation. At the time when Medicare was enacted, it was designed as an acute care program and consequently our administration of the home health benefit has also been oriented toward a need for skilled care.

Put negatively, our policies with respect to home health services are not oriented toward long-term care or custodial care for the chronically ill. It does not pay for such items as homemaker services or Meals on Wheels.

Specifically, the home health benefit has four major components: Part-time and intermittent skilled nursing care; physical, occupational and speech therapy; medical social services which are needed because social or emotional problems impede medical treatment of the patient's health condition; and part time and intermittent services from home health aides.

The law, section 1814, limits payment to those situations where the beneficiary's condition is so severe that he or she is under the care of a physician, is homebound, is in need of skilled nursing care, or PT on an intermittent basis, or a part-time basis, or is in need of physical or speech therapy.

Patients requiring skilled services for an indefinite time period will not have their services covered even if the services are billed on an intermittent basis.

In terms of the importance of the home health benefit we are aware of the initiatives that this administration took in 1983 to establish the prospective payment system for hospital reimbursement payments. Our experience, based on studies, indicates to us that the transfers that are occurring as a result of the PPS initiative are appropriate transfers in the vast majority of instances.

To the extent that some of those discharges may be premature, it is our intention, through the professional peer review program, to identify those situations and take remedial action.

But we still recognize that to the extent that we have heard testimony today it is not unreasonable to anticipate that some of the clients that are being discharged to home from hospitals may require a higher level of service and more intense services than perhaps had been the case in the past.

Second, we are well aware of the aging of the population, as well as State-specific changes, some of which we heard today, to promote the development of home health agencies through changes in the certificate of need law and licensure provisions.

These circumstances have prompted the administration to look far closer at the home health benefits. It was not only HCFA, but certain outside organizations that helped us, as it were, including the GAO and some internal studies in our Bureau of Quality Control. The data from those studies indicates that from 27 to 34 percent of the home health benefits that were being paid around the country were for noncovered care or nonmedically necessary care.

In a 1984 study it was projected that as much as $597 million was inappropriately paid by the program for care under the home health benefit.

The background, therefore, was one within which we had perceived substantial bodies of information, that the administration of the home health benefit was producing large amounts of inappropriately paid care.

We, therefore, took approximately five steps to address the issue. First of all, we established 10 intermediaries around the country in an effort to alleviate or hopefully eventually eliminate the inconsistencies in the decisions that we have heard something about here today.

We have developed, to further standardize the review process, the so-called forms 485 through 487.

These forms were developed in close consultation with the industry and are actively being revised to get insight into the kinds of considerations that are appropriate to adjudicate home health claims.

We have taken steps to computerize the screening of information from the 485's that we hope will likewise inject more normalization and better standardization into the review process.

We also took steps, some of which, apparently, some of the earlier speakers didn't think were such a good idea, by changing the HHA cost limits to make them focus on the various services provided by home health agencies.

And in that connection, I would simply point out that in establishing the rates, beginning in 1985 120 percent of the mean, what we were in effect saying was that if an agency or if the majority of agencies could operate at a certain level, we would throw in a 20-percent margin as an incentive to encourage, if you will, those agencies who are above the mean to come down to the mean.

So we gave a margin of 20 percent by saying that those means would be applied beginning at 120 percent and then decreasing downward for the next 3 years.

We also asked intermediaries to begin compliance reviews that would involve actually going into the homes of home health patients periodically to assure that the kinds of decisions that were being made were appropriate.

All of these activities, in fact, did result in an increase in the denial rates. Nationally, denial rates in 1984 were 2.5 percent. In the third quarter for fiscal year 1986 nationally they have gone up to 6.9 percent. I would say, however, that 6.9 percent is substantially less than what the GAO studies or internal studies would indicate was the scope of the inappropriately reimbursed home health benefits.

Maine is well below the national average, which as I indicated has gone up to 6.9 percent. I believe Maine is now at about 3 percent as of the March 1986 quarter, approximately half the national denial rate.

We believe this administration is committed to a restructuring of the system that permits and encourages a more integrated delivery system for all of the services that are intended to be provided for the Medicare population through capitation systems such as HMO's and competitive medical plans [CMP's].

Since April of 1985 we have signed 137 contracts with HMO's and CMP's around the country. Actually, we have them in 31 States.

By July 1986 we had 667,000 beneficiaries in HMO's and that number has now gone up to 736,000 as of the first of this month.

We recognize that the capitated system presents special problems in rural areas. And we are actively studying techniques that would lessen some of the requirements that would apply in other situations to promote and give advantages to HMO's that are interested in developing in rural areas. Much of the testimony today we are not insensitive to.

And we are doing demonstrations such as the social HMO that is in California, I believe with Kaiser, in our effort to study and evaluate possibilities in capitated environment; and eliminating

some of the kinds of restrictions that we may have heard about here today relative to the home health benefit in an effort to, as I say, encourage a more integrated and managed system of care for the elderly.

In conclusion, I would like to say that HCFA is committed to seeing that Medicare beneficiaries receive all the Medicare benefits covered by the program.

We will continue to do our very best to improve the administration of the home health benefit to assure fair, consistent determinations.

But I think that overall the data here clearly indicates that home health is an expanding program and we are, in the State of Maine, fortunate to have the New England Maine Blue Cross as the fiscal intermediary.

I can say personally that I know that the effort that the people at Maine Blue Cross have put into this has just been super, and I think that it has been recognized by not only local home health agencies but other agencies around the region.

I cannot conceive there is anything they should have done that they haven't done and we appreciate the efforts that they have taken.

Turning now to some of your questions, Madam Congresswoman. The definition of intermittency and homebound actually is discussed in my testimony on page 4. I will elaborate on it quite briefly.

Both the homebound and intermittent requirement are a part of 1814 of the original statute. I think it is important that all concerned recognize that these concepts are not something that HCFA dreamt up, but that they are imbedded in the actual legislation of 1814 of the statute.

Intermittency is a medically predictable recurring need for skilled nursing services or physical or occupational therapy, and some of the problems arise from that fundamental notion that I mentioned in the very beginning of my testimony of the orientation of the benefit to acute care.

It is our view that the intent of the intermittency requirement was to assure that the home health benefit was circumscribed to those situations that were oriented toward the tail end of an acute episode, and appropriately caring for that, in lieu of a commitment to a long-term care program of service to individuals in the home.

One of the key problems in that area is daily skilled care in the situation where beneficiaries may require skilled care on a daily basis.

Over time we have made an effort to address that issue. Our guidelines today do permit as much as 7 days a week for a short period and perhaps 2 to 3 weeks in instances perhaps not unlike the instances that one might encounter under the PPS discharge where there is an individual who does need a continuous, shall I say, thrust of skilled services to get them back on their feet after a period of—after a discharge.

So, as that has occurred, we have looked at that and have tried to clarify our guidelines, to the point where we are saying that 7 days a week for 2 or 3 weeks is not an unreasonable—is not necessarily inconsistent with the concept of intermittency.

We would even entertain a special documentation if the physician can help us in that regard to go beyond 2 or 3 weeks in certain circumstances.

But when it becomes clear in that situation that the kinds of care that the individual needs are going to be indefinite in nature, then it is true that, under our policies, it is our position that care is no longer covered under the Medicare Program.

With respect to the homebound requirement, that, too, is in the law. I would certainly want to point out that it is not our policy that an individual be bedridden. That is not in our manual, and I think it is quite clear that we do not require that an individual be bedridden.

I think the manual was quoted in terms of our instruction in that. But I think that in a sense, the homebound requirement is designed to address individuals who are in a sense unable to access the system, unable to get around or leave the home on a routine basis. If they have to do it with an awful lot of help, then we are not saying that that is violative of the homebound notion.

Similarly, if patients are otherwise eligible and relatives take them out for rides and take them out for—on the lawn or go around, it is not our intention to use the homebound requirement in an arbitrative, capricious way when common sense would tell somebody this individual is for all intents and purposes homebound.

With respect to the increased denial rates, I think I did touch on that on page eight of my prepared testimomy. I think, also, frankly, that I have touched on item three in your letter. At least I can't think of anything more to say.

The last point, the effect of the changes in reimbursement—again, it is our belief that the per-discipline cap beginning at 120 percent of the mean, is not an unreasonable approach, and that it does tend to promote efficiencies in the administration of the benefit, and we still feel that way.

Thank you very much.

Ms. SNOWE. Thank you, Mr. Kennedy, I appreciate your testimony.

[The prepared statement of John Kennedy follows:]

STATEMENT OF JOHN KENNEDY, REGIONAL ADMINISTRATOR, REGION I, HEALTH CARE FINANCING ADMINISTRATION

I AM PLEASED TO BE HERE TODAY TO DISCUSS HOME HEALTH CARE UNDER THE MEDICARE PROGRAM.

BACKGROUND

DURING THE 1980'S WE HAVE WITNESSED A DRAMATIC GROWTH IN HOME HEALTH SERVICES. THIS GROWTH STEMS PRIMARILY FROM CHANGES IN MEDICARE WHICH, BEGINNING WITH ENACTMENT OF THE OMNIBUS RECONCILIATION ACT OF 1980 (ORA), REMOVED CERTAIN PAYMENT, COVERAGE, AND PARTICIPATION RESTRICTIONS. THIS LEGISLATION SIGNIFICANTLY EXPANDED THE MEDICARE HOME HEALTH BENEFIT BY REMOVING THE LIMIT ON THE NUMBER OF COVERED HOME HEALTH VISITS, ELIMINATING THE REQUIREMENT FOR A PRIOR HOSPITAL STAY, ELIMINATING THE DEDUCTIBLE, AND ALLOWING MORE PROPRIETARY HOME HEALTH AGENCIES TO PARTICIPATE IN THE PROGAM.

EVEN THOUGH HOME HEALTH EXPENDITURES CONSTITUTE ONLY SLIGHTLY MORE THAN THREE PERCENT OF OVERALL MEDICARE BENEFIT PAYMENTS, THEY ARE GROWING RAPIDLY. FROM 1973 TO 1980, MEDICARE PAYMENTS FOR HOME HEALTH CARE INCREASED AT AN AVERAGE ANNUAL RATE OF ABOUT 33 PERCENT. MEDICARE HOME HEALTH EXPENDITURES DOUBLED BETWEEN 1980 AND 1983, FROM $800 MILLION TO $1.6 BILLION, BEFORE RISING TO NEARLY $2.4 BILLION IN FY 1985. THEY ARE PROJECTED TO REACH ALMOST $4 BILLION BY FY 1990. MAINE'S RATE OF HOME HEALTH EXPENDITURES FOR MEDICARE DURING THIS PERIOD HAVE ALSO GROWN SIGNIFICANTLY, RISING FROM $3.8 MILLION IN 1980 TO $6.0 MILLION IN 1985.

THE LEGISLATIVE CHANGES MADE BY ORA HAVE ALSO INCREASED UTILIZATION OF HOME HEALTH SERVICES BY MEDICARE BENEFICIARIES. SINCE 1980, THE ANNUAL NUMBER OF HOME HEALTH VISITS PROVIDED TO MEDICARE PATIENTS HAS GROWN BY 78 PERCENT FROM 23 MILLION IN 1980 TO 41 MILLION VISITS IN 1984. IN 1984, 1.5 MILLION BENEFICIARIES RECEIVED HOME HEALTH SERVICES COMPARED TO LESS THAN ONE MILLION IN 1980.

ALONG WITH THE LEGISLATIVE CHANGES AND THE GROWTH IN HOME HEALTH USE, WE HAVE SEEN A CONCOMITANT GROWTH OF 110 PERCENT IN THE NUMBER OF PARTICIPATING HOME HEALTH AGENCIES, FROM ABOUT 2,900 IN 1980 TO ABOUT 6,000 SO FAR IN 1986. THE MAJORITY OF THIS GROWTH HAS BEEN IN THE NUMBER OF PROPRIETARY HOME HEALTH AGENCIES, WHICH NOW NUMBER ABOUT 2,000, UP FROM JUST UNDER 165 IN 1980. MAINE CURRENTLY HAS 16 HOME HEALTH AGENCIES, THREE OF WHICH ARE PROPRIETARY. THESE 16 AGENCIES SERVED OVER 7,600 OF MAINE'S 167,000 MEDICARE ENROLLEES IN 1984.

BEFORE DISCUSSING CURRENT MEDICARE HOME HEALTH ISSUES AND DESCRIBING OUR INITIATIVES IN THIS AREA, I WOULD LIKE TO DESCRIBE BRIEFLY THE SCOPE OF THE MEDICARE HOME HEALTH BENEFIT.

THE MEDICARE HOME HEALTH BENEFIT

MEDICARE, AS ORIGINALLY ENACTED, IS AN ACUTE CARE PROGRAM WITH SERVICES DESIGNED TO SUPPORT THIS CONCEPT. CONSISTENT WITH THIS PRINCIPLE, MEDICARE'S HOME HEALTH BENEFITS ARE ORIENTED TOWARD A NEED FOR SKILLED CARE; THE BENEFITS WERE DESIGNED TO BE PART OF THE CONTINUUM OF CARE IN AN ACUTE EPISODE, USUALLY FOLLOWING HOSPITALIZATION. THE MEDICARE HOME HEALTH BENEFIT IS NOT ORIENTED TOWARD PROVIDING LONG TERM CARE FOR CHRONICALLY ILL INDIVIDUALS, NOR DOES IT PAY FOR SOCIAL SERVICES SUCH AS HOMEMAKER SERVICES OR MEALS ON WHEELS.

UNDER THE MEDICARE HOME HEALTH BENEFIT, THE FOLLOWING TYPES OF SERVICES ARE COVERED:

- PART-TIME AND INTERMITTENT SKILLED NURSING CARE PROVIDED BY OR UNDER THE SUPERVISION OF A REGISTERED PROFESSIONAL NURSE;

- PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY;

- MEDICAL SOCIAL SERVICES WHICH CONTRIBUTE SIGNIFICANTLY TO THE TREATMENT OF A PATIENT'S HEALTH CONDITION; THAT IS, SUCH SERVICES ARE NEEDED BECAUSE SOCIAL OR EMOTIONAL PROBLEMS IMPEDE THE MEDICAL TREATMENT;

- o Part-time and intermittent services from a home health aide; and

- o Medical supplies (other than drugs and biologicals) and medical appliances.

The Medicare law limits payment for home health services to those beneficiaries whose conditions are of such severity that the individuals are under the care of a physician, confined to their homes (homebound) and in need of skilled nursing care on an intermittent basis, or in need of physical or speech therapy. The care must be prescribed by a physician, and the services must be provided by a Medicare certified home health agency (HHA) in accordance with the physician's treatment plan.

Daily skilled nursing and aide services have never been considered to meet the statutory requirement of intermittent need. Guidelines have always restricted coverage of daily care to a short period of time to conform to the requirement for intermittent care. Consequently, any patient who requires daily nursing or aide care for what appears to be an indefinite time period will not have such care covered under the Medicare program, even if the services are <u>billed</u> to Medicare on an intermittent basis.

I should note that Congress is currently considering legislation, as part of the budget reconciliation process, which would expand the waiver of liability for services provided to beneficiaries who did not meet the homebound or intermittent care requirements. This waiver would permit reimbursement for home health services in these situations, where beneficiaries and providers were unaware that the eligibility requirements had not been met. Currently, the waiver applies only to the medically necessary and custodial care requirements. Additionally, the legislation would allow HHAs to appeal denials of homebound and intermittent care services. I think it is interesting to note that an internal HCFA study has shown that less than two percent of all HHA denials are made in these areas.

HEIGHTENED INTEREST IN HOME HEALTH

We are aware of a heightened interest in all Medicare post-hospital benefits. That interest has increased as a result of the implementation, in late 1983, of Medicare's prospective payment system (PPS) for hospitals. The positive incentives within PPS for efficient management of health care resources have resulted in a significant drop in hospital lengths of stay and have prompted an appropriate transfer of care from the inpatient hospital setting to various outpatient settings.

Other factors contributing to the heightening of interest in home health services include the aging of the American population, the growing sophistication of home health services that expands the kinds of illnesses that can be treated at home, and State-specific changes in licensure and certificate of need requirements that have encouraged proliferation of home health facilities.

IMPROVED ADMINISTRATION

HCFA is committed to paying for all home health care covered under the provisions of the Medicare statute. Nevertheless, studies conducted by the General Accounting Office (GAO) and HCFA's Bureau of Quality Control (BQC) from 1981-1984 indicated that between 27 and 34 percent of all home health visits billed to Medicare were medically unnecessary or not covered by the program. The most recent study we conducted projected payments for noncovered care in FY 1984 at $597 million. If this rate were to continue unabated, an additional $4.1 billion would be paid by Medicare for noncovered care between FYs 1985-89. The findings of these successive studies, coupled with the escalation in Medicare home health expenditures and utilization, make it imperative that only medically necessary services are furnished to beneficiaries by home health agencies. To assure that this is occurring in a manner consistent with the direction of both the Congress and GAO to improve the administration of the home health benefit, we have undertaken a number of activities.

Let me describe just a few of these.

HOME HEALTH INITIATIVES

AMONG THE ACTIVITIES HCFA HAS UNDERWAY TO STRENGTHEN THE ADMINISTRATION OF THE MEDICARE HOME HEALTH BENEFIT IS A REALIGNMENT OF THE HHA CLAIMS PROCESSING STRUCTURE. FIRST, WE ARE REDUCING THE NUMBER OF FISCAL INTERMEDIARIES (FIS) SERVING FREESTANDING HHAS (THOSE NOT AFFILIATED WITH ANOTHER PROVIDER) FROM 47 TO 10. ONE OF THE SELECTED INTERMEDIARIES IS ASSOCIATED HOSPITAL SERVICES OF MAINE. THIS REDUCTION WILL RESULT IN IMPROVED CONSISTENCY IN COVERAGE DETERMINATIONS AMONG FISCAL INTERMEDIARIES. THE FINAL NOTICE IMPLEMENTING THIS REQUIREMENT, WHICH WAS MANDATED UNDER THE DEFICIT REDUCTION ACT OF 1984, WAS PUBLISHED IN THE FEDERAL REGISTER IN FEBRUARY 1986. THE TRANSITION TO 10 FISCAL INTERMEDIARIES SERVING FREESTANDING HOME HEALTH AGENCIES WILL BEGIN ON OCTOBER 1, 1986, AND SHOULD BE COMPLETED BY OCTOBER 1, 1987.

SECOND, TO FURTHER REINFORCE CONSISTENCY AMONG INTERMEDIARIES, HCFA IS NOW REQUIRING HHAS TO COMPLETE A UNIFORM SET OF INFORMATIONAL FORMS FOR ALL FIS TO USE IN MAKING PAYMENT DETERMINATIONS. THE NEW HOME HEALTH FORMS-- DEVELOPED WITH EXTENSIVE INPUT FROM THE HOME HEALTH INDUSTRY-- ARE DESIGNED TO ASSURE THAT INFORMATION NECESSARY TO MAKE APPROPRIATE MEDICAL REVIEW DETERMINATIONS IS SUPPLIED BY HHAS WHEN THE CLAIM IS SUBMITTED. WE EXPECT THAT THE USE OF THESE NEW FORMS WILL RESULT IN MORE UNIFORM AND ACCURATE PAYMENT DETERMINATIONS. COMPUTERIZED SCREENS HAVE BEEN DEVELOPED IN CONJUNCTION WITH THE NEW REPORTING FORMS AND ARE NOW BEING TESTED. WHEN THE SCREENS ARE IN PLACE NATIONALLY, PLANNED FOR EARLY 1987, THE AMOUNT OF WORK NECESSARY FOR INTERMEDIARIES TO CONDUCT MEDICA' REVIEWS OF HOME HEALTH CLAIMS WILL BE GREATLY REDUCED.

INCREASED REVIEWS BY FISCAL INTERMEDIARIES AND THE USE OF THE NEW REPORTING FORMS HAVE RESULTED IN AN INCREASE IN DENIAL RATES. NATIONALLY, DENIAL RATES HAVE RISEN FROM 2.5 PERCENT IN FY 1984 TO 6.9 PERCENT IN THE THIRD QUARTER OF FY 1986. THE DENIAL RATE IN MAINE HAVE SHOWN A SIMILAR PATTERN OF INCREASE DURING THIS TIME PERIOD--BUT, AT ABOUT 3

PERCENT AS OF THE BEGINNING OF JULY, CONTINUE TO BE WELL BELOW THE NATIONAL AVERAGE. HOWEVER, THE OVERALL PATTERN OF INCREASE IS APPROPRIATE IN VIEW OF THE FINDINGS OF THE STUDIES REGARDING THE PROVISION OF UNNECESSARY OR UNCOVERED CARE WHICH I MENTIONED EARLIER.

WE HAVE ALSO MODIFIED THE WAY WE CALCULATE HOME HEALTH COST LIMITS TO REFLECT MORE ACCURATELY THE ACTUAL EXPERIENCE OF HOME HEALTH AGENCIES. SINCE JULY 1, 1985, COST LIMITS HAVE BEEN BASED ON THE ACTUAL PER VISIT COST FOR EACH DISCIPLINE, RATHER THAN ON AGGREGATE AGENCY COST, AS WAS DONE IN PREVIOUS YEARS. APPLICATION OF COST LIMITS ON AN AGGREGATE BASIS HAS HAD THE EFFECT OF SUBSIDIZING THE INEFFICIENT PROVISION OF SOME SERVICES BY BALANCING THE COSTS OF THESE SERVICES WITH MORE EFFICIENT, LESS COSTLY SERVICES. THUS, WHILE THE EFFECT OF THE CHANGE TO PER DISCIPLINE COST LIMITS IS TOO RECENT TO BE ASSESSED, THE PURPOSE OF THE NEW LIMITS IS TO ENCOURAGE MORE EFFICIENT OPERATION OF PARTICIPATING HHAs.

TO EASE THE TRANSITION FROM PREVIOUS COST LIMITS, WE ARE PHASING IN THE LIMITS OVER THREE YEARS BEGINNING LAST JULY 1, WHEN THE LIMITS WERE SET AT 120 PERCENT OF THE MEAN. BEGINNING JULY 1, 1986, THE LIMITS WERE SET AT 115 PERCENT OF THE MEAN AND WILL BE SET AT 112 PERCENT OF THE MEAN BEGINNING JULY 1, 1987.

CONGRESS IS CONSIDERING A RECONCILIATION PROVISION WHICH WOULD APPLY THE COST LIMITS IN THE AGGREGATE. THESE PROVISIONS ALSO WOULD REQUIRE THE GAO TO STUDY THE APPROPRIATENESS OF APPLYING COST LIMITS ON A DISCIPLINE SPECIFIC RATHER THAN ON AN AGGREGATE BASIS.

IN ADDITION, FISCAL INTERMEDIARIES BEGAN MAKING HOME VISITS IN NOVEMBER, 1984. THESE VISITS ARE INTENDED TO HELP ENSURE THE PROVISION OF QUALITY HEALTH CARE AND HHA COMPLIANCE WITH PROGRAM REQUIREMENTS AFFECTING PATIENT CARE. THEY ALSO ARE MEANT TO HELP PREVENT HHAs FROM SUBMITTING CLAIMS FOR UNNECESSARY OR UNCOVERED SERVICES. STATE SURVEY OFFICIALS WILL BEGIN MAKING SIMILAR VISITS IN FY 1987.

ALTERNATIVE DELIVERY MECHANISMS

FINALLY, WE ARE LOOKING AT OTHER WAYS OF DELIVERING HEALTH CARE THAT MIGHT PROVIDE A BETTER MIX OF SERVICES OR IMPROVE DELIVERY MECHANISMS TO ADDRESS THE CHANGING NEEDS OF OUR BENEFICIARIES. FOR EXAMPLE, UNDER THE SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION, WE ARE TESTING WHETHER PROVIDING A BROAD ARRAY OF BOTH MEDICAL AND SOCIAL SERVICES TO PATIENTS WILL ENABLE THEM TO MAINTAIN THEIR INDEPENDENCE WITHIN THE COMMUNITY AND FORESTALL INSTITUTIONAL CARE. THE RESULTS OF THIS DEMONSTRATION WILL NOT BE AVAILABLE FOR SEVERAL YEARS.

WE BELIEVE, HOWEVER, THAT THE BEST POTENTIAL FOR MAKING SERVICES AVAILABLE TO OUR BENEFICIARIES UNDER ALTERNATIVE PROGRAMS LIES WITH CAPITATED HEALTH CARE SYSTEMS SUCH AS HEALTH MAINTENANCE ORGANIZATIONS (HMOs) AND COMPETITIVE MEDICAL PLANS (CMPs). WITH THE RECENTLY IMPLEMENTED PROVISIONS THAT PROVIDE FINANCIAL INCENTIVES FOR HMOs AND CMPS TO ENROLL MEDICARE BENEFICIARIES, WE HAVE SEEN A RAPID GROWTH IN PLAN PARTICIPATION AND MEDICARE ENROLLMENT. UNDER THESE PLANS, BENEFICIARIES OFTEN RECEIVE MORE BENEFITS THAN UNDER THE TRADITIONAL MEDICARE PROGRAM WITH LOWER OUT-OF-POCKET COST. AND, THEY WELCOME THE OPPORTUNITY PROVIDED BY HMOs/CMPs FOR CASE-MANAGED CARE. PROVIDERS ARE PAID PROSPECTIVELY ESTABLISHED RATES AND ARE REWARDED FOR EFFICIENT OPERATION. SINCE APRIL 1985, WE HAVE ENTERED INTO 137 CONTRACTS WITH HMOs/CMPs IN 31 STATES. BY THE BEGINNING OF JULY 1986, OVER 667,000 BENEFICIARIES WERE ENROLLED IN THESE PROGRAMS, WHICH ARE ATTRACTIVE TO BENEFICIARIES AND PROVIDERS ALIKE.

WE WANT TO BUILD ON THE SUCCESS OF OUR HMO/CMP PROGRAM BY PERMITTING MEDICARE BENEFICIARIES TO USE A VOUCHER TO PURCHASE THE HEALTH INSURANCE COVERAGE MOST APPROPRIATE TO THEIR NEEDS. A BILL HAS BEEN INTRODUCED THAT WOULD ACCOMPLISH THIS. THIS VOUCHER PROPOSAL WOULD FOSTER COMPETITION AMONG HEALTH CARE PLANS AS THEY MARKET THEIR PARTICULAR BENEFIT PACKAGES TO BENEFICIARIES IN THEIR AREAS. THE PLANS WOULD BE PAID A PROSPECTIVELY DETERMINED RATE FOR

PROVIDING SERVICES THAT NEED NOT FOLLOW THE TRADITIONAL MEDICARE BENEFIT SCHEME, BUT MUST BE WORTH AN EQUIVALENT AMOUNT. WE BELIEVE THAT BOTH BENEFICIARIES AND HEALTH INSURERS WILL BE ATTRACTED TO THE VOUCHER ARRANGEMENT.

CONCLUSION

IN CONCLUSION, LET ME ASSURE YOU THAT WE ARE COMMITTED TO SEEING THAT MEDICARE BENEFICIARIES RECEIVE ALL NECESSARY CARE COVERED BY THE PROGRAM. THE INCREASE IN EXPENDITURES AND UTILIZATION FOR HOME HEALTH CARE ATTESTS TO THE CONTINUED DEMAND FOR AND PROVISION OF HOME HEALTH SERVICES. OUR ACTIVITIES ARE DIRECTED AT ASSURING THAT APPROPRIATE, MEDICALLY NECESSARY CARE IS PROVIDED WHICH MEETS THE POST-ACUTE DEFINITION OF HOME CARE SERVICES, AS SPELLED OUT IN THE LAW. WE CONTINUE TO INVESTIGATE IMPROVED APPROACHES TO MEETING THE NEEDS OF OUR BENEFICIARIES AND BELIEVE THAT CAPITATED HEALTH CARE PLANS OFFER ENORMOUS POTENTIAL FOR THE FUTURE.

Ms. SNOWE. Mr. Howard.

STATEMENT OF FRED I. HOWARD

Mr. HOWARD. I will try to cut some of this down because I notice we are already beyond the intended time, and John and the other speakers have certainly covered many of the things I want to say.

Some of this will be redundant, I am sure. But just a quick background—Maine Blue Cross/Blue Shield has been the fiscal intermediary for the State of Maine since its inception in 1966.

Basically, our accountabilities to administer the program can be categorized in three general groupings. We are responsible for, No. 1, and key, is making appropriate benefit determinations that are consistent with Medicare regulations. That is what we are paid to do.

We are responsible for the auditing of provider financial records to ensure that they are appropriately reimbursed.

And, finally, after listening to Betsy—I am not sure I want to say this—we process claims received from providers on a timely basis. We obviously have had some problems with that. They have related to a number of things that have been alluded to by a number of people today.

Primarily, they have been held up in the medical review area. I will get back to that a little bit later when I address how we are going to handle the transition of the out-of-State agencies to Maine.

Overall, our responsibility is to administer the program within the general framework that HCFA establishes. I guess one of the most difficult areas of administration that we contend with is servicing home health agencies as it relates to coverage issues.

I guess, in my opinion, and in the opinion of a number of our people, we believe that over time there has been tremendous progress in terms of the agencies' understanding as to what services are covered under the Medicare Program.

We expect that there will be further improvement with the advent to the new medical review forms that Mr. Kennedy referred to, and this ultimately will result in more consistency in the administration on a national level.

There has been mention that our rates have increased. It also has been mentioned that the denial rate in Maine is still below the national average, and I am not sure whether that is good or bad. I am not making that kind of a judgment. We may be losing something, but we——

Mr. KENNEDY. For today's purposes it is all right.

Mr. HOWARD. There are a couple of things you asked me to comment on. One was the 5 to 1 recovery rate.

This is a standard—for people who are not familiar with it, it is one of the critical standards. As a matter of fact, performance standards require that we recover $5 for every dollar we spend in administrative costs when we make a review.

Frankly, we failed that element in 1985. I am not sure—well, I guess I am fairly sure that we are going to fail that in 1986. I might as well tell you in advance. That is the way it is. We believe the agencies in the State of Maine do understand this program.

They do understand basically what types of services are covered. They are not submitting a lot of claims that maybe are submitted in other areas. And so, I think that is a part of the reason that the rate is determined in whole. But I think the point we want to stress most of all is I don't feel that our job is to try to deny claims.

Our job is to try to make benefit determinations that are accurate and consistent with Medicare rates. Our responsibility is to pay for services that are covered under the program. That is what we want to do.

I would mention briefly that in Baltimore at a meeting we attended—this was a meeting of the 10 national intermediaries—HCFA said to us exactly what I said to you, that they are not interested in the level of denials.

We don't care if there are zero denial rates, so long as you pay the benefits appropriately and that sort of thing.

The 5-to-1 rate really when you get down to it doesn't mean an awful lot. If we were able to get the denial rates way down and we could reduce our administrative costs, begin reviewing less claims, the spread would be different.

Instead of spending $100,000, $500,000, we might spend $5,000 in administrative costs, so the impact on the agency would not be—would be less denials, but we could still meet that standard under those kinds of circumstances. I think there is a way for that to happen and I think that is something that could very well happen.

I think the thing that is closest to my heart at the moment is our assumption of the role of regional intermediary for the home health agencies in region 1.

I guess it has been stated under the Deficit Reduction Act of 1984—Congress said there will be no more than 10 intermediaries to handle home health agencies. That was reduced, I think it was 47 to 10.

Another of your questions, and questions that we hear from the system—I don't think we are hearing as much anymore is—can we handle the program? How is it going to impact on service in the State of Maine? How is it going to impact on the service outside of the State of Maine?

I am 100 percent convinced that there will not be an adverse impact on Maine providers, nor on providers in other areas of New England.

I believe the service will improve in both areas and for a couple on three or four reasons that I will just quickly mention and then I will let you ask the questions.

I guess maybe you want to get back to some of the other points, but we have begun adjusting staffing levels to accommodate the additional volume.

They have—this will be a continuing process as the agencies convert on their fiscal year, end beginning October 1, 1986, and 1 full year cycle before they all will be converted. So we are preparing for that. And claims processing administrative review the net result to us in Maine is that there will be an addition of about 60 people.

We will have—most of the employees will be functioning out of the State of Maine with a couple of exceptions.

We intend to have the people in the other New England States strategically located so they will be available to help with education and so they can do the onsite medical review type of thing that we have to do at the facility. And we will have some audit people that will also be stationed out of State. Just from an economic point of view it makes more sense to have them close to the reviewers.

We have developed a dedicated medical review unit. Hopefully it will answer some points that Betsy made. I agree with them. We have had some problems. We have been increasing our staff there. We have added nursing power. We have just assigned a management position there to give more intensive training. We know there are some inconsistencies.

We look at the same cases and come up with a different answer. Emphasis is being placed on that. We will end up with a very large department to review the medical activities for the entire region. We will do our own considerations there. Independent people will not have seen the original determination.

We will go through a review process which is a preliminary thing, informal type of thing. We stated to the agency, if you miss something get it to us quick and we will take another look at it, and let's apply it to the official for reconsideration.

We have a dedicated processing unit, and I guess for the first time ever—we used to have provider relations people assigned to Medicare for budgetary reasons.

We don't get a lot of money anymore to administer this program. We have had to cut out in the past some of the activities that we felt were important.

With this program we felt it was an absolute necessity to establish a provider relations group, and that is the group that will be primarily stationed outside with the manager stationed in our office. Incidentally, we were extremely fortunate to be able to hire Beverly Tyrrell who was former executive director of South Portland Home Health Agency and past president of Maine Community Health Associates—Betsy, for 2 years?

Ms. PERRY. At least.

Mr. HOWARD. So we have been trying to demonstrate our good faith. We want to see both sides. We want to understand your side, I think. Some of the nurses that we are hiring have come from within home health background. So I think we are heading this thing in the right direction, and I think our service will be improving, and I think the agencies outside of the region will see the improvements.

A number of other things that we have done, we are holding provider education workshops. They have already begun. We have had a couple in Maine. As a matter of fact, Worcester, MA, is holding another one. Those will be ongoing. We have installed a toll free telephone line at this point in the region.

We have met with the other intermediaries in the region, defining what our needs are going to be in terms of documentation, transition material, et cetera, over the next year, cost reports and waiver statistics, whatever. That has been done.

We have regular transition meetings with HFCA people in Boston, in fact, yesterday, and that allows them to feel—hopefully feel comfortable with the progress we are making.

We have a timeframe established. We are on the timeframe at the moment. Things are going extremely well according to our schedule.

Ms. SNOWE. Mr. Howard, could you summarize your statement?

Mr. HOWARD. Well, I guess the balance of it really is some more—some of those additional activities that I—that you might be interested in where you raised the question, what kind of things, so you could feel confortable that your counterparts are doing in the State of Maine? Is Maine going to be able to handle this and what are the reasons? That is the technical reason I included that. I think I could say that is pretty much.

Ms. SNOWE. You have covered most of the major points.

Mr. HOWARD. I appreciate the opportunity.

[The prepared statement of Fred Howard follows:]

PREPARED STATEMENT OF FRED I. HOWARD, JR., VICE PRESIDENT,
GOVERNMENT PROGRAMS, ASSOCIATED HOSPITAL SERVICE OF MAINE

Since the inception of the Medicare Program in 1966, Associated Hospital Service of Maine, d/b/a, Blue Cross and Blue Shield of Maine, has served as fiscal intermediary for Part A of the Medicare Program in the State of Maine.

As the fiscal intermediary, Blue Cross and Blue Shield of Maine is responsible for the administration of the Medicare Program in the State of Maine. Our accountabilities can be combined into three general categories. We are responsible for making benefit determinations that are consistent with the Medicare regulations, the auditing of provider financial records to ensure that providers are appropriately reimbursed, and, finally, to process claims received from providers on a timely basis.

In the State of Maine we now service fifty hospitals, sixteen skilled nursing facilities, sixteen home health agencies, and twenty-six rural health clinics.

In our capacity as fiscal intermediary, we are responsible for the administration of the program within the general framework of the guidelines provided by the Health Care Financing Administration.
Since the subject of this hearing is specific to home health care, my discussion will be limited to comments related to the Medicare Home Health Care Program.

The major problem we contend with in servicing the Medicare certified home health agencies relate to coverage issues. We believe significant progress has been made in terms of understanding what services are covered under the Medicare Program in the home setting. This understanding has become even clearer with the advent of the new medical review forms that HCFA has developed. During the phase-in of the new medical review form the denial rate has increased. This was not unexpected and we believe improvement will be seen as the agencies become more familiar with the use of the form.

One of the more significant problems we encounter as the fiscal intermediary relates to a HCFA standard that requires the fiscal intermediary to recover five dollars for every one dollar spent in medical review. It is a critical

element in the HCFA performance standards and we expect this will continue to be a difficult standard to meet. The basic reason we have difficulty meeting this standard is because the home health agencies in the State of Maine have developed a good understanding of the regulations and no longer submit claims for services they know are not covered under the program resulting in fewer denials. Our primary goal is to ensure that our benefit determinations are accurate and consistent with the Medicare regulations.

The last point of discussion relates to the selection of Blue Cross and Blue Shield of Maine as the regional intermediary to service all free-standing home health agencies in New England.

The Deficit Reduction Act of 1984 requires that the number of the intermediaries designated to service free-standing home health agencies be limited to not more than ten. The goal of this legislation is to achieve more consistent and effective administration of the home health benefit under the Medicare Program.

Our assumption of the new role of regional intermediary will result in no adverse impact on the service we provide to home health agencies located in the State of Maine, nor will it adversely affect agencies located in the other New England states.

Conversely, we fully expect the level of service to improve as a direct result of the dedicated specialty services we will provide as described in the following paragraphs.

Our staffing patterns are being adjusted accordingly to meet the increased workloads in claims processing, medical review activities and in audit and reimbursement. The net result will be an increase of approximately sixty employees, the majority of which will be located in the State of Maine.

We have established a dedicated medical review department, a reconsideration-quality-control-utilization-review department, a dedicated claims processing unit, and a provider relations department with responsibility for on-going provider education and external medical review activities.

Provider education workshops have already been held in Maine and additional workshops will be scheduled through the coming year to accommodate agencies as they are transferred from their existing intermediary to Blue Cross and Blue Shield of Maine.

An integral part of our provider education program includes the development of a Regional Home Health Agency Claims Manual which contains specific instructions in all phases of provider billing requirements. The manual will be supplied to all free-standing agencies in New England.

To further assist in ensuring a smooth transition we have met with all of the existing intermediaries to establish mechanisms for transferring required data to Blue Cross and Blue Shield of Maine on a timely basis.

The official transition begins October 1, 1986 and will be completed one year later as the agencies are transferred on the first day of the month following their fiscal year end.

This concludes my testimony. I will be happy to respond to questions at this time.

Ms. SNOWE. I just wanted to get some of the questions to both of you before we conclude this hearing.

Mr. Kennedy and Mr. Howard, obviously there seems to be a great deal of confusion about the definitions of "homebound," intermittent care and so on.

I received a number of complaints from home health agencies with respect to that definition. And as you have heard this morning testimony by other witnesses that they, too, have been unclear in terms of what "homebound" means and if that means bedbound.

Now, where has the confusion developed with respect to this definition, and has HCFA gone beyond the interpretation of the statute to define it is bedbound, essentially?

Mr. KENNEDY. I certainly hope not, Congresswoman.

The testimony today on occasion referenced discussions that had been had with representatives, I guess, of intermediaries and/or perhaps HCFA itself.

If anyone would care to call to my attention the specifics in those instances, I can assure you that we will investigate them and find out where those perceptions arose and correct them.

But I think that the standard manual that we issued that discusses the guidelines clearly indicates that it does not mean that the individual has to be bed confined.

If, in fact, there have been instances where conflicting decisions could arise as to whether or not the particular circumstances in that individual case constituted homebound, then we are in a judgmental area.

But to arrive at the conclusion and to avoid the necessity of making the difficult decision as to whether or not homebound existed by simply relying on a cookbook reference, well, if they are not bedconfined, then to just deny the benefit is not appropriate, and has never been the intention of the administration of the benefit.

Again, I would be more than happy if anyone would care to call those instances to our attention, we would be—I can assure you we will correct that.

Ms. SNOWE. Well, how would you define homebound?

Mr. KENNEDY. Well, the homebound requirement, I can read you what the manual says. That is always the safest thing, I suppose, but I would like to go beyond that.

Ms. SNOWE. Isn't if more the application of that definition in the statute that seems to be where the problem is?

Mr. KENNEDY. I think one of the preceding panelists actually read the definition. I think that is taken right out of the intermediary manual, if I am not mistaken.

There exists a normal inability to leave home. Consequently, leaving their homes would require a considerable and taxing effort. Patients may still be considered homebound if they leave their homes infrequently or for periods of short duration, as long as this does not demonstrate their capacity to obtain care outside, rather than in the home.

The definition, to the extent that that definition applies, always has to take into account the facts in the individual case. Oftentimes we hear and—we hear complaints about, well, you don't define things specifically.

The problem, of course, is that when you do define things specifically and you put clear definitions in—there is always going to be the case that it doesn't make common sense.

So what we prefer to do is to set out what we believe to be the thrust of it; namely, that for all intents and purposes, notwithstanding the fact that the relative might take the individual out for a ride, notwithstanding, with a walker a person can get down and get the mail, notwithstanding the certain abilities to move around outside the home with difficulty—that is, it does not mean that the person does not meet the homebound requirement.

So we think that it is preferable to give an idea, and a pretty clear idea, of what we are talking about, but not to go to the level of specificity that would come back to haunt us in individual situations, because when you are administering a benefit for millions and millions of people across the country, invariably there are going to be circumstances you can never anticipate.

We would rather leave the intermediaries with flexibility, with knowledgeable staff—trained staff to make those decisions. We think that is a better way to go.

Ms. SNOWE. Do you, Mr. Howard, have difficulty in determining what is meant by homebound in processing claims, and do you deny claims on that basis?

Mr. HOWARD. Absolutely. I would say it is a very small percent of the total claims that are denied. There are not many that are denied for that reason.

Ms. SNOWE. There are not many?

Mr. HOWARD. There are not many.

Mr. KENNEDY. According to the study that we did not too long ago, the technical denials for the homebound intermediary amounted to 2.7 percent of the total denials.

Mr. HOWARD. It is very small.

Mr. KENNEDY. It is a relatively small thing. But I hate to take over. I think, too, that there are other extremes to that. I mentioned some of the studies that had gone on. There are instances that have been called to my attention.

I personally am well aware of this because I had to testify on this issue before a Senator from Florida several years ago where it was quite clear that by no stretch of the imagination were the individuals that we were paying home health benefits to homebound.

They certainly were not homebound. They were at the track. They were—if you know—if you get my drift. There is an extreme in the other direction.

Ms. SNOWE. What about the ratio for denial for every $5 in benefits for every $1 in administrative costs? How long has that been implemented and what is the rationale for it?

It seems to me that if you create a ratio for denial of benefits you create a very inflexible way of approaching home health care. By just saying that you have to reach a certain goal makes it very difficult. I think that it places considerable pressure on the intermediary and home health agency to deny individuals accesss to home health care.

What is the reasoning behind it? How long has it been implemented? I would like to hear from you, Mr. Howard, about the difficulties in implementing and what happens if you don't reach your

goals. What are the penalties involved for failing to meet the 5-to-1 ratio?

Mr. HOWARD. The penalty—we have set performance standards, and some of those standards contain critical elements. There are about three or four or five critical elements in the set of standards.

This happens to be one of them, so what it does is that it ends up that we fail to meet a critical standard of performance standard. That is brought to mind to us, and we don't like to see that.

Ms. SNOWE. So other than——

Mr. HOWARD. There is no financial——

Ms. SNOWE. There is no penalty?

Mr. HOWARD. No financial penalty.

Ms. SNOWE. Do you feel considerable pressure to meet that goal or do you just ignore it?

Mr. HOWARD. No. We definitely—we are not doing that. We are not ignoring it, and we do feel some pressure to meet it.

Ms. SNOWE. With that, I mean do you try to ignore it in dealing with borderline cases. I mean, that is obviously where the problem is going to develop.

At what point are you actually aware of the fact that you have to meet this inflexible 5-to-1 ratio in denying benefits?

Mr. HOWARD. In the second or third year, and we know what that goal is, and we know where we stand in relation to that goal on a month-to-month basis.

If we continue at this rate we are only going to be 2-to-1 or 3-to-1, whatever.

Again, primarily, our people are trying to adjudicate the claim, pay the benefits that are appropriate, and they don't even know about it. They have no part of that 5-to-1 recovery. It is a standard.

Ms. SNOWE. But you are aware of——

Mr. HOWARD. Yes.

Ms. SNOWE. Couldn't that account for the increase in denial of benefits?

Mr. HOWARD. No. I do not believe that.

Ms. SNOWE. What do you think accounts for it?

Mr. HOWARD. That applies to one that was having it before our denial rate started to go up.

Ms. SNOWE. What do you think accounts for the increased denial of benefits?

Mr. HOWARD. The increase?

Ms. SNOWE. Yes.

Mr. HOWARD. I think one of the things is the advent of the new medical review form, the 485 through 487 service. I think that gave us more information to work with, and I think the fact that we are now staffing and training, giving people more intensive training with better supervision, I think, has had some impact. But 'I really—I wouldn't be comfortable in saying that I think the 5-to-1 has any direct relationship to that. I would not.

Ms. SNOWE. Mr. Kennedy, why does Medicare—why does it matter to Medicare if individuals decide to supplement their services in the home? As I understand it, Medicare would deny reimbursement if an individual gets any additional assistance, either through other professionals or by the family?

Mr. KENNEDY. No. I—stated that way I don't know of any requirement that would cause us to deny, simply for that reason. But let me go back to my earlier——

Ms. SNOWE. On what basis would you deny it?

Mr. KENNEDY. Well, it goes back to that issue of intermittent. The answer, the need that the individual has. If, in fact, the need for long-term care versus intermittent care is demonstrated, then it is our policy to say that that is not an individual that is entitled to home health services.

Ms. SNOWE. I guess I don't understand that rationale because I think that we also encourage home health care whenever possible, certainly for a lot of reasons, whether it is cost effective or because it is easier for individuals to remain at home because oftentimes they improve.

I have known people who stayed at home and they feel better being home in their familiar environment. So I guess I don't understand why it matters to Medicare if somebody is getting additional care that suggests longer-term care. Certainly it—it could represent in the long term less money to the Government if an individual decides to supplement that care and that individual can remain at home.

Mr. KENNEDY. Well, I think someone who wants to supplement the care that they otherwise—there would be covered care under Medicare. There is no prohibition against that.

Ms. SNOWE. But they are running the risk of losing their benefits ultimately if you define it as not intermittent care or longer term care requiring institutional care.

Mr. KENNEDY. I would look at that as a situation where the individual's requirements are for a long-term investment of skilled nursing services and if, in fact, that is what the supplementary payments are paying for, and we are aware of that, then I think we would have to reach the conclusion that that is not a patient who meets the intermittent requirement. As a patient, it is not a bias against them spending their own money. It is a bias in the sense of whether or not they are the kind of individual that the program is designed to accommodate.

Ms. SNOWE. I guess that is where I disagree because I think as long as somebody can remain at home, and wants to remain at home, then they should be able to remain at home. So I think that that is the approach and policy and that is what it should be for the U.S. Government rather than saying you have to be institutionalized because now you have gone beyond the threshold, and you require *X* amount of care on a weekly or daily basis.

Mr. KENNEDY. I can certainly understand why someone would look at it that way. All I can say is that it is my belief that our policy on intermittency requires us to look to the client and to the patient in terms of their needs and the expected level of their needs and expected duration of that level. If the conclusion is that those needs go beyond intermittent levels, then that person is not eligible for home health benefit—benefits under Medicare.

Ms. SNOWE. What about the cost reimbursement methodology that has now been adopted? As was mentioned earlier by previous witnesses, there is very little flexibility in the reimbursement mechanism for home health care and Medicare. For example, pre-

viously if home health agencies were reimbursed for one service and it cost less, they could shift the additional savings to something else like hospitals do under DRG's.

As Betsy Perry mentioned, they have discontinued providing occupational therapy because they are not now adequately reimbursed for that service.

Mr. KENNEDY. Well, it was our view that a heightened measure of incentive would be injected into the administration of the home health program by focusing on the specialized services that they provide, and to give that incentive in a way whereby if, in fact, an agency's cost for a service is over 120 percent of the mean for the country, then there is something that they could do to reduce those costs. And in the absence of it, there is very little incentive for them to do it.

It was felt that the opportunities were greater if it were focused on the individual service, rather than any aggregate. Now, I hate to comment on the particular occupational therapy case that was mentioned in the earlier testimony because I simply don't know the facts of that circumstance. Frankly, it was my impression that none of the home health agencies had bumped up against the rates—the separate caps, but apparently I am wrong on that.

I was talking to Fred and I don't know what happened. I didn't get the impression there was any that had exceeded the limits. That there is an occupational therapy limit someplace that has been bumped up against in the State of Maine is a function of a lot of different complicating factors and I hesitate to comment beyond what was mentioned earlier.

But, yes, occupational therapists are not, shall we say, available throughout a widespread area such as Maine and there may be certain cost inefficiencies in attempting to provide that directly. Apparently there is some consideration being given to doing it under contract to avoid the cap. If that works, then the incentive is working.

Ms. SNOWE. Well, then, has it been your experience that other agencies have been able to live within——

Mr. KENNEDY. As far as the State of Maine is concerned, it is my clear impression that has not been a problem for the agencies in the State of Maine.

Ms. SNOWE. Is rurality weighted in the reimbursements at all? That is a factor in the State of Maine and requires long distances for traveling.

Mr. KENNEDY. It is weighted in the sense that there is a lot of distance to travel in Wyoming and Montana and elsewhere around the country.

Ms. SNOWE. But is it weighted; is it a consideration?

Mr. KENNEDY. Well, it is a consideration in the sense that their costs are factored into the mean. So if it costs more in Montana, then Maine gets the advantage. Likewise, if Maine costs more, Montana gets the advantage.

Ms. SNOWE. I can see the difficulties. What about prompt payments, Mr. Howard? I gather there are varying impressions as to whether there is a quick turnaround on payments. Can you give me an estimate on how long it takes to turn around claims?

Mr. HOWARD. As of yesterday, I did take a look at that to see what our inventory was and we have 16-day inventory on hand.

Ms. SNOWE. Sixteen days?

Mr. HOWARD. Sixteen day inventory—work-on-hand it is called. Now, that does not mean that in 16 days every one of those claims is submitted. The clean claims alluded to earlier do not require us to obtain additional documents. The standard is 95 percent of those claims within 27 days.

Ms. SNOWE. On the clean claims?

Mr. HOWARD. On the clean claims.

Ms. SNOWE. Now, anyone that has a problem claim, how long does that take on the average?

Mr. HOWARD. Claims that require more information, the standard for those is 95 percent within 60 days and 100 percent of all claims with or without additional paperwork in 90 days. I have to go back and have someone pull the files, but I would say we have never reached an average turn out that would exceed 30 days. There may be some cases that would go to 90 days, but the majority of them would be turned around much quicker than that.

This is also on the performance standards and we consistently meet the standard. We have not failed the standards so somewhere there is a discrepancy in numbers. I will absolutely take a look when I get back.

Ms. SNOWE. How long does it take for a review process?

Mr. HOWARD. Well, reconsideration—it goes officially through reconsideration. Beyond that, we review it.

They are done by Connecticut Blue Cross. They do the appeals. I am not sure they do them for all of the region. I have to agree they could take as much as 35 to 40 days probably, which is excessively long, and that is the reason we are going to establish our own because of this increased on-site——

Ms. SNOWE. How do you account for the fact, concerning the example that was raised by Betsy Perry, with respect to the denial of 500 claims, of which 200 were reversed?

Mr. HOWARD. I can't give you an absolute answer. I can say that my feeling is that we have added new people there. We are trying to train them very specific—train them to the regulations, and I think they may be, because they are not fully trained, making those kinds of judgments incorrectly.

When they come back and somebody with a better background reviews them and says, gee, you made a mistake, you should have looked at this, and you should have looked at that, and turn the decision around. That is the only real explanation I could give you.

Ms. SNOWE. Since Blue Cross/Blue Shield of Maine will be the fiscal intermediary of New England, you will be receiving 60 additional employees, as I understand it?

Mr. HOWARD. Yes.

Ms. SNOWE. Will they be assigned for claims processing or what will their function be?

Mr. HOWARD. These are approximate numbers because I cannot remember them specifically, but approximately 24 in the medical review area, and that is a closed area. In the neighborhood of 10 in the claims processing area. In the vicinity of 16 to 18 in the audit and reimbursement area. These people will be phased in over this

period—well, it will be more than a year because the actual audits won't come out of State until 90 days after October 1986, so it would be late 1987 before some of these people will be added, anyway. So that accounts for most of them. The rest will be support people. We are—included is a full-time medical consultant who will begin on a part-time basis, but that is pretty much the commitment of them.

Ms. SNOWE. Mr. Kennedy, has HCFA ever considered DRG's for home health care reimbursement?

Mr. KENNEDY. At various times there were proposals for a prepayment methodology for home health, but I don't believe it ever—at least to my knowledge, there has been no discussion about it being passed under a DRG system. I could be wrong on that. But to my knowledge, no.

Ms. SNOWE. One final question, Mr. Howard. In making your determinations, do you factor in the costs that would be incurred if an individual were placed in a nursing home or in a hospital?

Mr. HOWARD. I believe the answer to that would be no. Our—we cannot administer—I think it is a heck of a good idea personally, and I think that is what we should look at, where it is more economical to treat this patient, as long as the quality of care is there. I agree that doesn't go into the equation. If this person is receiving a level of care of home health that we can pay for, that is all we really consider.

Ms. SNOWE. Mr. Kennedy, I do have one more question. I think it was Betsy Perry's testimony that intravenous medications are not reimbursable for home health care under medicare; is that true?

Mr. KENNEDY. Intravenous?

Ms. SNOWE. Intravenous medications.

Mr. KENNEDY. Gee, I am not an expert on those coverage issues. I mean, to the extent that injections require skilled service, they are certainly payable as a home benefit, assuming all the other requirements are met. I don't know what, though.

Ms. PERRY. The services are covered, the equipment is covered, but the medication is not?

Mr. KENNEDY. Yes.

Ms. SNOWE. Why wouldn't that be the case, because obviously you have to be, as she mentioned, taken by an ambulance in order to receive the intravenous treatment?

Mr. KENNEDY. I am getting in over my head here, which is not unusual for me, by the way. Is that the drugs and biologicals, et cetera? We don't pay for drugs and biologicals, that is why. It happens to be a drug and biological home health setting.

Ms. SNOWE. I think it is an illustration again of what home health care is intended to be and it sort of gets bogged down in some of these areas, where, it seems to me, if you use some flexibility and latitude, you can continue the health care. I think that is what it amounts to. Otherwise it becomes more costly than it would have been, to be transported by ambulance to receive the intravenous treatment because home health care doesn't get into medication.

Mr. HOWARD. That is true.

Ms. SNOWE. I appreciate your testimony and your appearance here today. It has been very helpful in clarifying some of the issues

and also in terms of some of the directions that might be taken in responding to the key issues that are of concern to home health agencies, and to the beneficiaries of home health care.

I appreciate your testimony and your presence and I thank you very much.

In conclusion, I want to thank all of the witnesses for appearing before this field hearing of the Subcommittee on Human Services and for sharing your thoughts with me. The record of this hearing will be given to other members of the subcommittee and Select Committee on Aging. In this way, they will be provided with your expertise and the benefit of your information as to how we can improve home health care delivery in this State, as well as in our region and throughout the country.

Home health care is a major priority in Congress. It certainly is a major priority for me, and I will continue to work, based on much of what I have learned here today, to try to address some of these problems in Congress. Clearly there are some changes I feel need to be made within the home health care delivery system. It is a system of care that I think we should emphasize in Congress. Perhaps we don't do enough to provide better services under home health care, rather than concentrating on institutional care.

So I want to commend all of the witnesses here today for giving me their perspectives and the benefit of their experience, given their individual roles in the home health care field here in the State of Maine, and with the Federal Government. I appreciate the witnesses' testimony and I appreciate the cooperation of the audience and their presence here today.

With that, this hearing is adjourned.

Thank you.

[Whereupon, at 1:30 p.m., the hearing was adjourned.]

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